Clinical psychologists and multi-disciplinary teams : an investigation into team/professional identification, job satisfaction and burnout in clinical psychologists

Thesis

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JON C. BOAKES BA Hons

Clinical Psychologists and Multi-disciplinary Teams: An investigation into team/professional identification, job satisfaction and burnout in clinical psychologists.

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ABSTRACT

Burnout and job satisfaction among 108 clinical psychologists working in multi-disciplinary teams (MDTs), was explored in relation to perceived team climate, clarity of team and personal role, and professional and team identificaton. The study employed a cross-sectional within-group and between-group design involving a quantitative and qualitative methodology to explore the relationship between variables.

Clinical psychologists reported high job satisfaction and high emotional exhaustion, and perceived team climate to be low on a number of aspects. Professional identification was higher than team identification, although team identification was strong. Team identification was associated with aspects of job satisfaction, but not burnout. Clarity regarding personal role in the team was positively associated with job satisfaction and negatively associated with emotional exhaustion. Clarity regarding the role of the team was associated with team identification and job satisfaction.

Multi-disciplinary team experience, experience as a psychologist, length of time and the number of sessions worked with the team, were not associated with team identification. Amount of contact with other psychologists was not associated with professional identification. Team climate was associated with job satisfaction and team identification.

The findings are discussed and the implications for services, clinical practice and clinical psychology training are addressed.

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1. INTRODUCTION

The current research project examines the professional and team identification of a large sample of clinical psychologists working within multi-disciplinary teams (MDTs) and across a range of client groups. The research explores how team and professional identification relate to job satisfaction, burnout, role clarity and aspects of team climate.

The concept of a team and models of teamwork based, upon Ovretveit's (1986) formulations are briefly outlined. The advantages of team-working and the specific benefits of multi-disciplinary teamwork for clinical psychology are presented in addition to negative experiences and criticisms voiced by clinical psychologists, with regards to the role of the psychologist in MDTs. West's (1990) model of team climate is presented and aspects of team climate based upon the model are described with reference to the community MDT literature.

The concepts of burnout and job satisfaction are in turn introduced and discussed in relation to research into health professionals working in community and hospital settings. Factors considered to be important for burnout in clinical psychologists in MDTs are highlighted. Factors considered important in influencing a clinical psychologist's team and professional identification are discussed and social identification theory is presented as a way to explore the experience of belonging to two groups.

1.1. Reasons for multi-disciplinary team working

Multi-disciplinary community teams have been established to meet the needs of a variety of client groups living in the community including: adults with mental health problems;

people with learning disabilities; older adults; and children and families (Ovretveit, 1986).

MDTs originated during the 1980's, at a time when individuals were being discharged from large hospitals to the community. The government's White Paper "*Caring for People*" (DoH, 1989), made no specific reference to MDTs, but emphasised the importance of effective collaboration between disciplines, "each recognising and respecting each others contributions and responsibilities" (p.13) in the delivery of locally based services to children, adults with mental health problems, and people with learning disabilities. Only recently however, have MDTs been promoted as formal government policy. The government report "*Building Bridges*" (DoH, 1995) which reviewed arrangements for the care and protection of the severely mentally ill, stated that "services should be provided on a multi-disciplinary team basis" (p.35) In addition, the Department of Health document *Spectrum of Care"* (DoH, 1996) advocated the MDT as a key indicator of effective interagency work, and required that a Community Mental Health Team be in place in each locality.

Ovretveit (1986) summarised some of the reasons for developing teamwork models of care delivery, highlighting how teamwork can draw upon the skills of a variety of professionals in a flexible way to meet the needs of a client. Clients as a consequence have easier and quicker access to a wider range of therapist's skills and therapeutic approaches. The complexity of a client's problem, which may include enduring health and social needs, dictates that no single profession will have all the necessary skills for effective intervention (Watts & Bennett, 1991). Team working provides opportunities for advice and support from other team members who share an understanding of the needs of

a particular client group. Professional liaison is perhaps most effective between people working under the same roof (Moss, 1994), where crucial information (e.g. clients history) can be shared and joint objectives discussed (Hattersley, 1995).

Team working can provide a safer context in which professionals can express the anxieties and stresses which they are likely to experience (Moss, 1994). It may also have a positive effect on staff motivation by maintaining interest and engagement, when working with complex and chronic problems (Watts & Bennett, 1991). Teams can provide "a nest for creativity", provided that team members feel safe and are given the opportunity to express their curiosity (Moss, 1994).

Watson (1990) describes how both clinical psychology and teams could benefit from having psychologists as core team members; Team working can improve communication between disciplines and lead to a greater appreciation of the role of the clinical psychologist. It can also provide opportunities to learn from colleagues "whether it is from their knowledge, skills or mistakes" (p.21). Clinical psychologists could be responsible for modelling helpful behaviour such as respect, curiosity, fairness and dispassionate thinking, and help team members to recognise and deal with unhelpful behaviour including conflicts and negative attitudes towards other staff and users.

1.2. Types of Team

A "team" is a collection of people brought together to complete a task, who interact with one another and perceive themselves to be a group (Cushway & Lodge, 1993). Ovretveit (1986) distinguishes "formal teams" from a "network" arrangement. In the latter, a team

does not exist in a true sense because "there is no permanent group with an agreed and formal membership or a collective objective which members are accountable for achieving" (p.11). In contrast, "formal teams" comprise a very clear membership and a collective responsibility exists among members for undertaking certain work. This role is formally recognised by individual members' managers. Ovretveit (1986) described a number of possible configurations of multi-disciplinary teams which are briefly outlined below. It is important to consider different models of team working as they have implications for the clinical psychologists within them.

The *fully managed team* refers to teams in which the team manager is responsible for all casework decisions; he/she assigns work to team members, has the authority to override clinical decisions and appraises individual members' performance. This model is often applied to teams of the same discipline, and is unsuitable for MDTs where members invariably have separate lines of professional accountability. It is rare for multi-disciplinary teams to be managed fully in this way, although in medically dominated teams the senior medic may assume these responsibilities irrespective of team members agreement (Onyett, 1992).

In the *co-ordinated team with shared management*, each team member has joint accountability to both a team co-ordinator and a professional line manager. Team co-ordinators, who may be nominated within the team, have responsibility and authority for convening meetings, ensuring arrangements for case co-ordination, and monitoring certain aspects of work. They cannot override clinical decisions of team members (Ovretveit,

1986). The main disadvantage of this model is the potential for disagreement between the objectives of professional line managers and those of the team manager. However, for professionals in teams, this model provides a balance between professional autonomy and team management (Onyett,1992).

In *joint accountability* or *democratic teams* there is no team leader with formally agreed authority and accountability; team members make all team decisions and share accountability. Ovretveit (1986) suggests that such teams, often popular with team members, can be effective if there are clear arrangements for decision making and management. Without such arrangements, teams may fail to confront difficult issues. Ovretveit (1986) described a further configuration in which a team comprises of *core* or full-time members from one or two professions fully-managed by the team leader, and *extended* or part-time specialist team members who are co-ordinated by the team manager.

Ovretveit (1986) states that there is little empirical evidence to support one model over another. Team configuration will depend upon the task of the team and the context in which the team is working. In a recent national survey of Community Mental Health Teams (CMHTs) there was an indication of a shift towards co-ordinated teams with shared management. In this survey, 74.5% of teams reported having a team manager or team co-ordinator, although management responsibilities were often not clearly defined (Onyett, Hepplestone & Bushnell, 1994).

Much of the research and discussion about MDT working has focused upon CMHTs, serving adults with mental health difficulties. The current research is focused upon MDTs

across specialisms and includes CMHTs and teams serving other client groups.

1.3. CLINICAL PSYCHOLOGY AND MDTs

Given the suggested benefits of team-working it is perhaps surprising that clinical psychology commentators have on the whole been critical about teams, describing the negative experience of psychologists. The professional literature in clinical psychology would suggest that psychologists feel particularly threatened by team membership. Anciano & Kirkpatrick (1990) in their article "*CMHTs and clinical psychology: the death of a profession*", are explicit about the seriousness of the threat. Galvin and McCarthy's (1994) reference to MDTs "*clinging to the wreckage*" and Paxton's (1995) editorial entitled "*Goodbye mental health teams-at last*" claim that CMHTs are a failed experiment, while Onyett (1996) argues to the contrary, citing not only an increase in their number, but also a number of successful teams. Onyett and Ford (1996) assert that the difficulties of some CMHTs are due to failure in the effective implementation of such a model, which includes over ambitious unfocused aims and confusion about accountability and responsibility.

A major criticism of MDTs by psychologists relates to the clinical psychologist's role within them. In the absence of a clearly defined role some teams adopt a "*generic mental health working stance*", confusing equal rights with equal skills, leading to arbitrary case allocation, rather than allocation based upon who has the most relevant skills (Anciano & Kirkpatrick, 1990; Clydesdale,1990). Responsibilities and duties overlap and become indistinct resulting in role blurring, demoralisation and deskilling. Specialist skills are often not recognised or utilised. In commenting upon potential areas of difficulty in

MDTs for older adults, Bradbury (1996) suggested that refusal to act as a generic worker, can lead to growing resentment and envy from other team members.

Working within MDTs may threaten psychological work other than direct clinical work. Within a context in which the number of client contacts are seen as "good currency", skills in research, teaching and working through other professionals, are at risk of being lost (Cushion, 1997). The loss of these skills may lead to psychologists feeling under valued and in a recent survey of CMHTs, clinical psychologists (n=13) were less likely than other disciplines, to agree that CMHTs allowed optimum use of training and skills (Mistral & Velleman, 1997). Such experiences give rise to feelings of "de-professionalisation" (Anciano & Kirkpatrick, 1990), which are amplified "when emblems of status (e.g. having their own office to see clients) are threatened in a context of limited resources" (Onyett, unpublished).

A further potential source of conflict lie in other professions (e.g. nurse therapists) laying claim to areas of expertise within therapy, which psychologists traditionally held (Trepka & Marsh, 1990). A clear role definition may prevent such conflict, but often the psychologist is left to negotiate his/her role, resulting in role definitions which are unspecified, vague or contradictory, and which receive little legitimacy outside the team (Trepka & Marsh, 1990).

Reiman (1989) in a study exploring the advantages and disadvantages for psychologists in MDT work with older adults, stated that psychologists found full-time participation in MDTs professionally isolating and unrewarding. Similarly, in Mistral and Velleman's

(1997) study, psychologists showed greater agreement than other disciplines with the statement that CMHTs were professionally isolating. Less contact with the psychology department and fewer opportunities for supervision (Anciano & Kirkpatrick, 1990) may also contribute to a loss of professional identity and development.

In considering the wider context in which professionals are having to justify and demonstrate the effectiveness of interventions and procedures, psychologists and other practitioners appear likely to find MDTs exposing of clinical practice (Alexander, 1992), resulting in some professional groups becoming more protective and less willing to share their clinical skills.

Accountability and responsibility are also a potential area of difficulty for psychologists within teams. Dual accountability models in which the psychologist is "professionally accountable" to a professional superior outside of the team and "managerially accountable" to a team manager or locality manager are described as a potential source of conflict and role ambiguity by Galvin and McCarthy (1994). Contentious issues, such as procedures for case allocation, are avoided. Where issues of accountability and responsibility are not well defined and agreed, psychologists may lack professional support, and may feel over directed by the local manager (Ovretveit, 1993).

Given clinical psychologist's expressed unease within MDTs, the present study aimed to explore psychologist's perception of the climate of the team in which they worked, and how this related to both job satisfaction and burnout. Team climate is an important area to consider in MDT work, as effective team-working necessitates that the 'climate' or

atmosphere within the team is facilitative of efficient performance.

1.4. TEAM CLIMATE

1.4.1. Definition of climate

Climate has been defined as the "collective current impressions, expectations, and feelings of the members of local work units. These in turn effect members relations with supervisors, with one another and with other units" (p.8) (Burke & Litwin, 1992). There has been much debate surrounding the conceptualisation of climate. The two main definitions which have received greater research attention are the "Cognitive Schema Approach" and the "Shared Perceptions Approach" (Anderson & West, 1994). The former conceptualises climate as an individual's constructive representation or cognitive schema of their work environment. The latter focuses on the shared perceptions of people in the work environment and not on the individual perspective. Anderson and West (1994) draw attention to the problems with the shared perceptions approach in that it is difficult to identify when perceptions from different individuals are shared.

Despite debate about the conceptualisation of climate, researchers agree that climate is an important intervening variable between input and output variables in organisational models (Ekwall, 1985). It is believed that climate influences, and is influenced by, psychological and organisational processes (Piero, Gonzalez-Roma & Ramos, 1992). Studies have demonstrated the existence of a relationship between team climate and outcome variables such as job satisfaction (Jackovsky & Slocum, 1988), performance (Kozlowski & Hults, 1987), productivity and staff turnover (Litwin & Stringer, 1968).

Anderson and West (1994) suggested that some of the problems in defining climate can be overcome when focusing upon "facet specific climates". In facet specific climates there is reference to the type of climate being defined, rather than the general climate. Such facet-specific climates may include "climate for change" and "climate for innovation" (Schneider & Reichers, 1983).

1.4.2. Four factor theory of climate (West, 1990)

West (1990) proposed a model for innovation which specifically focused upon research at the team level. Innovation was defined as the "intentional introduction and application within a group, of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit role performance, the group, the organisation and wider society". The following four major factors were related to innovation, and were predictive of effective team performance: *team vision*; *participative safety*; *task orientation* and *support for innovation.*

1.4.3. Team vision

Vision refers to the shared purpose or goal of team members, which focuses and directs their energies. Vision should be *clear, attainable* and *negotiated* and evolving out of future outcomes. Vision should be *shared* and *valued* by team members. Where team vision or values are inconsistent between individuals, the individual may become less motivated and less committed (West, 1994).

Major criticisms of MDT in mental health services concern issues around *vision.* While some teams have been established after clear planning (Lam & Abendorff, 1988) others

have emerged locally without any explicit plans (Reiman, 1989). Often there is uncertainty about the role of the team in relation to the overall organisation and other agencies, and in the absence of an agreed operational policy, team members may be left to struggle and define their own roles as well as team objectives (Hattersley, 1995; Galvin & McCarthy, 1994).

It is argued that teams often have imposed upon them a wide range of expectations, which are often unclear and even contradictory (Paxton, 1995). Teams are expected to: implement government policy; resolve tension between agencies; supply services to primary care teams; act as gate keepers to secondary care; function as both purchasers and providers of mental health care; and be a panacea for a range of mental health problems (Peck, 1995). Galvin and McCarthy (1994) argue that the complexity and poorly defined nature of tasks pushed onto teams often results in "unfocused, inefficient and low quality service provision" (p.157). It is argued that in Adult Mental Health, these difficulties have contributed to the neglect of people with severe and long term mental health needs (Galvin & McCarthy, 1994). Teams may also have to resolve complex issues such as the status of individual members, levels of competence, legal status, entitlement to practice autonomously, and functional interrelationships between professional groups, without any definitive central policy or guidance (Galvin & McCarthy, 1994).

1.4.4. Participative Safety

Participative safety incorporates the following concepts: *influence over decision making; information sharing; interaction frequency* and *safety* (West, 1994).

Where team members have *influence over decision making* they are more likely to contribute their energies and creative ideas to that process (West, 1994). Group process literature suggests that decisions are more likely to be implemented by group members if they work together in making those decisions (Cartwright & Zander, 1968). Rather than promoting decision making, MDTs have been criticised for lowering members intellectual contributions at team meetings, rarely resulting in any coherent operational description of problems, goals and interventions (Galvin & McCarthy, 1994). Managers are also often seen as providing too few opportunities for participation in decision making (Onyett & Ford, 1996).

Information sharing is important in creating opportunities to generate effective and creative ways of working. In a review of recommendations from recent government enquiries into mental health services, lack of information sharing was identified as a problem within mental health teams (Sheppard, 1996). *Interaction frequency* will determine the extent to which ideas, information and conflicting views will be exchanged (West, 1994). MDTs have been criticised for the lack of interdisciplinary collaboration taking place within them (Searle, 1991; Galvin & McCarthy 1994), and in Searle's (1991) study of a MDTs serving older adults, only 13% of cases involved more than one profession.

A climate of *psychological safety* is important for creativity to be engendered. When people feel safe they are more likely to show commitment and involvement in the team. Where team members feel unsafe they are less likely to offer ideas to improve the

functioning of teams (West, 1994) and less likely to take risks in collaborative work (Alexander, 1992; Searle, 1991). Some degree of conflict within MDTs is not only inevitable but also necessary to avoid 'group-think'. It is important that debate and dissent are encouraged in teams, since complex problems presented by patients require innovation and flexibility (Holloway, 1988).

1.4.5. Task Orientation

High *task orientation* is characterised by *reflexivity,* constructive controversy and a commitment to *excellence* (West, 1994). Team members feel their competence is affirmed rather than attacked and there is a climate of co-operation and mutual trust. Critical appraisal is seen as a healthy process rather than a negative one. Team members in a high task orientation team critically reflect upon their objectives, processes and strategies. This strengthens ownership of policy whilst clarifying where development is needed (Pilling, 1991).

The extent to which MDTs critically review, amend or elaborate upon the above aspects is unclear from the literature. There is an indication that teams have relatively low task orientation. Recent government enquiries into mental health services have highlighted the deficiencies of MDTs in reviewing record keeping, policies and procedures. The lack of appraisal of work relationships, both within and outside the team, was also identified as problematic (Sheppard, 1996).

Unconscious group processes appear to play an important role in effecting a team's ability to critically reflect and work towards its objectives. Bion (1994) distinguishes between

groups which work towards their primary task ("*work group mentality*") and groups who have a tendency to avoid work upon the primary task ("*basic assumption groups*"). In the latter, one of three basic assumptions may be held by group members, particularly in situations where there is a lack of clarity regarding the task. The basic assumptions include: *dependency*; *fight/flight*; and *pairing*. Such unconscious processes have been observed within MDTs (Stokes, 1997). Assumptions are unconscious, serving to avoid the reality of the group's task and purpose, and evading the painful reality and conflict between group members. As a result group members anxiety is reduced and internal conflicts are avoided.

1.4.6. Support for Innovation

Support for innovation is a significant predictor of innovation and creativity in teams. Anderson and West (1994) distinguish between *articulated support* and *enacted support*. Articulated suppo.t refers to innovative activity which is verbally encouraged. Enacted support refers to support for innovation in terms of time, resources and co-operation.

1.5. BURNOUT.

There is a lack of consensus in defining burnout, although there are certain elements which are shared, and Maslach and Jackson's (1981) definition is the most widely employed. Burnout is defined as a syndrome comprising of *emotional exhaustion*, *depersonalisation* and a *reduced sense of accomplishment*, which can occur among individuals who work in close contact with other people (Maslach & Jackson, 1984). *Emotional exhaustion* refers to feelings of being emotionally extended and drained by one's work with other people.

Depersonalisation refers to an unfeeling and cynical response towards the people one works with. *Reduced personal accomplishment* refers to a decline in one's feeling of competence and achievement when working with people.

In a recent study of 250 Community Psychiatric Nurses (CPNs) (Carson, Fagin & Ritter, 1995), CPNs reported high levels of emotional exhaustion and personal accomplishment, and moderate depersonalisation. Research into mental health nursing has identified poor communication, lack of consultation (Sullivan, 1993), low role clarity (Firth, McIntee, McKeown & Britton, 1987) and lack of social support at work (Cronin-Stubbs & Brophy, 1984), as predictive of burnout among mental health nurses. Individuals who communicated extensively about work but maintained few informal supportive relationships had higher burnout in a study of 34 members of a multi-disciplinary mental health team (Leiter, 1988). A recent meta-analysis of burnout in mental health nursing, indicated that high burnout was associated with: low job satisfaction; low staff support; low involvement in the organisation; and role conflict and ambiguity (Melchior, Bours, Schmitz & Wittich, 1997).

The above factors reported to be associated with burnout in CPNs, appear similar to the difficulties expressed by clinical psychologists regarding teams. One would therefore expect burnout to be a salient issue for psychologists working within MDTs.

Other factors important in predicting the degree of burnout include those relating to client complexity, chronicity and prognosis (Pines & Maslach, 1982). If this is the case, one might expect psychologists to differ in the degree of burnout according to the

speciality in which they work. The gender of psychologists may also play a part. In a recent national survey, female doctors and female managers experienced higher levels of stress as assessed by the GHQ-12 (Hardy, unpublished). A meta-analytic review of variables associated with burnout, suggested there was moderate evidence of an association between female gender and burnout in mental health nursing (Schaufeli, 1990). One might expect these findings to be replicated with clinical psychologists.

Walsh, Nichols and Cormack (1991) suggested that clinical psychologists have been reluctant to seek support at work. They reported that this partly reflected a fear of being stigmatised, and also a perception that work colleagues were "untrustworthy" or not sufficiently equipped to meet their needs. Expression of the need for support was also perceived as a threat to job security. Although this research was not specifically related to MDT members, one might expect such feelings to be strong in this type of setting.

In Onyett *et al.*'s (1997) study of burnout and job satisfaction of members of CMHTs, in adult mental health, participants' experienced significantly higher emotional exhaustion and personal accomplishment, and significantly lower depersonalisation, than the norms on the Maslach Burnout Inventory (MBI). Clinical psychologists, psychiatrists, social workers and CPNs, were among the most emotionally exhausted disciplines. High levels of burnout were associated with low job satisfaction in this study.

1.6. JOB SATISFACTION.

Job satisfaction has been defined as "a pleasurable or positive emotional state resulting from appraisal of one's job or job experience"(p.1300) (Locke, 1976). Debate exists as to

whether job satisfaction is an outcome measure in its own right, or a source of stress and burnout (Cooper & Baglioni, 1988). Many studies have found job satisfaction to be correlated with burnout (Kahill, 1988), and a few studies have found that specific aspects such as satisfaction with co-workers, are clearly associated (Kahill, 1988).

The Occupational Stress Indicator (OSI) has been used to measure job satisfaction and stress. A study of 1176 NHS employees compared job satisfaction, and stress at work, with that of non-health service white collar workers, using OSI norms (Cooper, Sloan & Williams, 1988). Both groups had similar levels of job satisfaction and while Health workers reported significantly greater pressure of work, they had fewer symptoms of poor mental health (Rees & Cooper, 1992). More recently, Onyett *et al.* (1997) in their study of burnout and job satisfaction in members of CMHTs, used the job satisfaction scale from the OSI. Although job satisfaction across the disciplines was significantly higher than Rees and Cooper's (1992) study, clinical psychologists had comparatively low satisfaction with work relationships compared with other disciplines. Surprisingly they had higher satisfaction with achievement, value and growth, which the authors suggested reflected psychologist's autonomy and relatively high status in teams (Onyett *et al.*, 1997).

1.7. GROUP IDENTIFICATION AND MDTs.

Roberts (1997) in discussing psychodynamic processes operating within teams, describes individuals having multiple group memberships outside of the work group, such as church, sporting and family memberships. Such multiple group memberships are not important where the work group is concerned. However, in some situations being a

member of one group (e.g. a professional group) will be the reason for being selected to another group (e.g. MDT). Roberts (1997) argues that the effectiveness of MDTs is dependent on the ability of team members to manage and balance their professional and team memberships. Excessive commitment to either will inevitably compromise task performance and lead to problematic group relations.

Social identity theory, developed from European social psychology, describes the derivation of a positive sense of self through group membership and inter-group comparison (Tajfel & Turner, 1979). Social identification is a construct which enables one to explore the experience of belonging to two groups and the tension this creates. Onyett, Pillinger and Muijen (1997) suggested that a professional worker joining a Community Mental Health Team (CMHT) becomes a member of two groups: the profession and the team. Identification with these groups may be conflicting or complementary depending upon the culture and practices of particular professional groups. Team members may find themselves torn between the collectivist ideals of team working and a desire to hold onto traditional, socially-valued role definitions and practices.

Social identification suggests that people gain part of their self concept from group membership. Social identification theory predicts that where team goals threaten an individual's identification with a more socially valued group such as a professional group, positive feelings towards the team are less likely to result. With reference to clinical psychologists in MDTs, where clear team goals are identified with strong team operational management, this can conflict with the psychologist's professional identity and autonomous practitioner role. Conflict between team and professional identification is

perhaps greater for clinical psychologists. In Onyett *et al.*'s (1997) study of CMHTs, clinical psychologists (n=34) were found to have lower team identification, and higher professional identification compared to other professions.

Resolution of group conflict is demonstrated in situations where an individual's team and professional identification can co-exist. This is likely to occur when an individual has a clear and valued role in achieving team goals (Deschamps & Brown, 1983). Social identity theory applied to MDTs, suggests that increased job satisfaction, reduced burnout and less role ambiguity, will occur when staff are able to achieve a positive sense of identification with the team, which is not undermined by their professional identification. This is supported by Onyett *et al.* (1997) who found that members of CMHTs who had both high team and high professional identification, experienced higher job satisfaction and less burnout.

1.7.1. Factors predicted to be important in a psychologist's team/professional identification.

Clarity regarding the team's aims and objectives may lead to greater commitment, a sense of common purpose and consequently a greater sense of identification with the team (Cushway & Lodge, 1993). The extent to which the psychologist feels involved in decision making may predict team identification (Cushway & Lodge, 1993).

The amount of contact the psychologist has with MDT members may also influence team identification (Brown, Condor, Mathews, Wade & Williams 1986). Psychologists who work a greater number of sessions, or who have worked for greater lengths of time with the team may experience greater team identification (Roberts, 1997). In addition, group

research predicts that having an office base with the team increases interaction and encourages greater co-operation, thereby increasing team identification (Cushway & Lodge, 1993).

A further factor which may be important in team identification, is the speciality in which the psychologist works. Although there is little empirical evidence to support this, anecdotal evidence suggests that some teams, particularly those serving client groups with complex and multiple needs (e.g. learning disability; rehabilitation) require a greater degree of collaboration between disciplines in the team, thus increasing members team identification.

The amount of contact psychologists have with their professional colleagues may effect both team and professional identification (Brown *et al.*, 1986). One could predict that where there are few opportunities for contact with other psychologists, professional identification may be weaker. A balance between professional and team identification will require a strong professional identification, achieved through contact with other clinical psychologists. Where there are other psychologists in the speciality, or team, professional identification maybe stronger.

Finally, experience as a clinical psychologist may also be important for team identification; for newly qualified clinicians, professional identity may be more salient, than team identification. In addition, a psychologists previous experience of multi-disciplinary team work may also impact upon their team identification and role clarity, to a positive or negative extent.

2. RESEARCH AIMS AND HYPOTHESES

2.1. Research Aims

There has been little empirical research exploring the experience of clinical psychologists working within MDTs. The current research aims to assess clinical psychologist's perceptions of MDT climate. The research also assesses job satisfaction and burnout in clinical psychologists to assess how these factors relate to: aspects of team climate; team identification; professional identification and role clarity. Specific research hypotheses are detailed below. Based upon previous research evidence the hypotheses have been stated in a predictive form. Two-tailed tests were used as part of a more conservative approach to hypothesis testing.

2.2. Research Hypotheses

1. Professional identification and team identification.

Hypothesis 1: H_1 Clinical psychologist's professional identification will be significantly higher than their level of team identification.

2. Relationship between team identification and job satisfaction and burnout.

Hypothesis 2: H_1 A high team identification will be associated with high job satisfaction and low burnout.

3. Role Clarity.

Hypothesis 3: H_1 High personal role clarity and high team role clarity will be associated with high team identification, high job satisfaction and low burnout.

4. The relationship between team/ professional identification and other factors.

Hypotheses 4.1-4.5:

4.1: H_1 Clinical psychologists who have a greater length of experience working in MDTs will have higher team identification.

4.2: H_1 Clinical psychologists who have worked for a greater length of time within their current team will have higher team identification.

4.3: H_1 Clinical psychologists who work a greater number of sessions per week with the team will have higher team identification.

4.4: H_1 Clinical psychologists who have greater experience within the profession will have higher professional identification.

4.5: H_1 Clinical psychologists who have a greater amount of contact with other psychologists will have higher professional identification.

5. "High" team and professional identification and the dependent measures.

Hypothesis 5: H_1 Clinical psychologists with both "high" team and "high" professional identification will have greater job satisfaction and lower burnout compared with other groups.

6. Relationship between team climate, team identification and dependent variables.

Hypothesis 6: H_1 A high positive team climate will be associated with high team identification, high job satisfaction and low burnout

7. Exploratory Data Analysis.

Gender.
Hypothesis 7.1: H1 Female clinical psychologists will have higher burnout than male psychologists.

Dependants.
Hypothesis 7.2: H1 Clinical psychologists with dependants will have higher burnout than those psychologists without dependants.

Leadership role.
Hypothesis 7.3: H1 Clinical psychologists who hold a leadership role within the team will have higher levels of team identification and job satisfaction, and lower burnout than psychologists who do not hold a leadership role.

Office base.
Hypothesis 7.4 : H1 Clinical psychologists who have an office base with the team will have higher levels of team identification than those psychologists who do not have an office base with the team.

Frequency of team meetings.
Hypothesis 7.5 : H1 Clinical psychologists who are members of teams which meet frequently will have higher levels of team identification than psychologists who are members of teams which meet less frequently.

Psychologist alone in speciality.
Hypothesis 7.6 : H1 Clinical psychologists who work alone in a speciality will have higher burnout, lower job satisfaction and lower professional identification than psychologists who do not work alone in a speciality.

Psychologist alone in team.
Hypothesis 7.7 : H1 Clinical psychologists who are the only psychologist in the team will have lower professional identification, lower job satisfaction and higher burnout than psychologists who are not the only psychologist.

Speciality
Hypothesis 7.8 : H1 Clinical psychologists working in learning disability or rehabilitation will have higher team identification than psychologists working in other specialities.

3. METHODOLOGY

3.1. Design

The current study employed a cross-sectional within-group and between-group design involving a quantitative and qualitative methodology to explore the relationship between a number of variables described in *section 3.4.*

The main independent variables were team identification, professional identification, role clarity, team climate and the individual characteristics of the clinical psychologist (including amount of MDT experience, number of sessions worked in the team, and amount of contact with other psychologists). Dependent variables were measures of burnout and job satisfaction.

3.2. Definition of Multi-disciplinary Team

In the current study a multi-disciplinary team was defined using the criteria in Table 1. These criteria were adapted from Onyett, Hepplestone and Bushnell's (1994) national survey of community mental health teams. For the purpose of the current study the definition also included teams working in other specialisms, in addition to adult mental health.

Table 1. Definition of multi-disciplinary team.

(1) The team does most of its work outside of hospitals, although it may be hospital based.
(2) The team has 4 or more members.
(3) The team is recognised as a multi-disciplinary team of two or more disciplines by service managers
(4) The team is essentially a secondary or tertiary level of service. Teams may serve: people with learning disabilities; older adults; children or adults with mental health problems. Tertiary level teams, such as those working with addictions are also included. Primary care teams are excluded.

3.3. PARTICIPANTS AND RECRUITMENT

3.3.1. Participant criteria for inclusion

Potential participants were clinical psychologists who worked within the NHS in multi-disciplinary teams. In order to be eligible to take part in the study the clinical psychologist worked within a multi-disciplinary team, as defined by the criteria in Table 1.

As many psychologists work part-time within teams (Onyett *et al.*, 1995), it was specified that in order to participate in the study the psychologist should work a minimum of 1 day (2 sessions) per week with the team. Where a psychologist was a member of two or more teams, they were asked to comment upon their experience of working in the team in which they had most input.

3.3.2. Recruitment

The names of potential participants were obtained from the South Thames Regional Clinical Psychology Directory. The head/advisor of each Clinical Psychology Service in the South Thames region was approached by the researcher. The nature of the research was briefly outlined, and each head/advisor was asked to identify which clinical psychologists in their service currently worked within multi-disciplinary teams, as defined by the research criteria. In total, 208 clinical psychologists were identified as meeting inclusion criteria for the study.

3.3.3. Description of the sample

Of the 208 participants who were sent questionnaires, 108 returned completed measures, representing a 52.2% response rate. Table 2 describes the general characteristics of the sample.

Table 2. Characteristics of clinical psychologists forming the sample in this study.

		n	percent
Speciality	Adult Rehab/Continuing Care	15	13.9%
	Adult Mental Health	46	42.6%
	Older Adult	9	8.3%
	Children & Families	18	16.7%
	Learning Disability	15	13.9%
	Other	5	4.6%
Gender	Male	32	29.6%
	Female	75	69.4%
	Omitted	1	0.9%

	Mean	**SD***	**Range**
Number of days per week with MDT (to nearest half day)	3.46	1.16	1 -5
Total MDT experience (months)	85.7	60.98	3 - 276
Time with current team (months)	29.55	31.81	1 - 160
Number of years experience as clinical psychologist	9.37	7.41	1 - 29

*SD = Standard deviation

3.3.4. Non-participants

A further sample of N = 26 (26% of the total number of non-respondents) gave reasons for non-participation via a form devised for this purpose. These included work related pressures (N=5) and length of the questionnaire (N=2). 16 of the sample reported not meeting the criteria for a team as outlined on the questionnaire front sheet, and N=3 reported that they were counselling or occupational psychologists.

3.4. MEASURES

3.4.1. Team Climate Inventory (Anderson & West, 1994) (Appendix I)

The Team Climate Inventory (TCI) is a 44 item questionnaire which assesses perceived work group climate across 4 broad climate factors (*participative safety, support for*

innovation, vision and *task orientation*), divided into 15 sub-factors (Appendix II). Participants rate their agreement with various statements on a 5 point Likert scale ranging from strongly disagree (1) to strongly agree (5). The Questionnaire is divided into 3 sections: communication and innovation; objectives; and task style. Raw scores on each of the four broad climate factors and 15 sub-factors are converted to *sten scores.* Sten scores are standard scores on a 1-10 scale with a mean of 5.5 and a standard deviation of 2.

The TCI also includes a *social desirability* scale, which aims to examine where respondents are giving "falsely positive ratings of team climate - too positive to be likely in reality" (p.21, Anderson & West, 1994). The social desirability scale comprises 6 items measuring response bias. Normed responses are not incorporated for the social desirability scale. The items are added together, and a score above 20 suggests an "unacceptably high social desirability response and a definite response bias" (Anderson & West, 1994). A score between 10 and 19 indicates some social desirability evident, while a score below 10 indicates an acceptable low level of social desirability.

The TCI has been extensively validated, and the internal reliability of the climate factors ranged from 0.84 to 0.94 (Anderson & West, 1994). Norms are provided from a sample of teams from a diversity of organisational settings including 118 members of 20 mental health teams based in the north of England.

3.4.2. Occupational Stress Indicator: *How you feel about your job* (Cooper, Sloan & Williams, 1988) (Appendix III).

This published scale, consists of 22 items, measuring job satisfaction, taken from the Occupational Stress Indicator (Cooper, Sloan & Williams, 1988). Participants rate work satisfaction on a 6 point scale (where 6 = very much satisfaction, 1 = very much dissatisfaction). Higher scores on this measure therefore indicate greater satisfaction. The job satisfaction scale has five sub-scales:

1. *Achievement, value and growth* examines opportunities for advancement, how valued respondents felt and whether their job was rewarding.

2. *Job itself* measures satisfaction with the type of work undertaken.

3. *Organisational design and structure* examines how well an organisation functions.

4. *Organisational processes* examines perceptions of whether the organisation facilitates or prevents achievement.

5. *Personal relationships* examines the quality of personal relationships at work.

The validity and reliability of this scale has been established (Robertson, Cooper & Williams, 1990). Although originally designed for professional groups in industry, this scale has been applied to a variety of health service workers. Rees and Cooper's (1992) study of 1176 NHS employees provides a source of comparative data. More recently, Onyett *et al.* (1997) used this scale to assess job satisfaction among 445 members of community mental health teams.

3.4.3. Maslach Burnout Inventory (Maslach & Jackson, 1986) (Appendix IV)

The Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1986) assesses three aspects of the burnout syndrome: *emotional exhaustion*; *depersonalisation* and *lack of personal*

accomplishment. The MBI consists of 22 statements of job related feelings, and participants rate on a 0-6 point scale how frequently they experience these feelings (where 0 = never and 6 = every day). A high score on the *emotional exhaustion* and *depersonalisation* sub-scales indicate higher emotional exhaustion and depersonalisation, whereas a low score on the *personal accomplishment* scale indicates lower personal accomplishment.

The reliability and validity of the MBI has been well established (Maslach & Jackson, 1986). Norms are provided for a number of workers in the human services including 730 mental health workers (Maslach & Jackson, 1986). A comparative sample of members of CMHTs are also available from Onyett *et al.* (1997). The wording of four MBI items in Onyett *et al.*'s study (1997) were slightly modified in order to be more acceptable to an English sample. These slight modifications were also incorporated into the MBI used in the current study. A factor analysis conducted by Onyett *et al.* (1997) confirmed that the original three-dimensional factor structure of emotional exhaustion, depersonalisation and personal accomplishment was maintained with these modifications. Inter item reliability scores for the MBI sub-scales were measured using Cronbach's alpha coefficient: emotional exhaustion =0.89, personal accomplishment =0.77, and depersonalisation =0.73.

3.4.4. Team Identification Scale and Professional Identification Scale (Onyett, Pillinger & Muijen, 1997) (Appendix V)

Both the team identification and professional identification scales are measures which have been adapted from a scale developed by Brown, Condor, Mathews, Wade &

Williams, (1986). The team identification scale consists of 8 items, 4 of which affirm and 4 of which deny *team identification*. A high score indicates greater team identification. A similar 8 item scale measures *professional identification*. Participants rate their agreement with a number of statements on a 5 point scale where 0= strongly disagree and 4=strongly agree. A high score on this scale indicates greater professional identification. The identification scale has established reliability and validity (Brown *et al.*, 1986). Comparative data are available from Onyett *et al.*'s (1997) study of CMHTs. Internal reliability of the team identification scale and the professional identification scale were 0.85 and 0.83 respectively.

3.4.5. Personal/Team Role Clarity Scale (Rizzo, House & Lirtzman, 1970) (Appendix VI)

Personal and team role clarity were measured using scales adapted from the role ambiguity scale developed by Rizzo et al. (1970). *Personal role clarity* assesses the extent to which an individual is clear about his/her responsibilities, who he/she is accountable to and how his/her work will be evaluated. *Team role clarity* refers to the extent to which the team is seen as having clear aims and priorities, including clarity about who the team is trying to help.

Each scale consists of 7 statements, which participants have to rate their agreement with on a scale of 0 (strongly disagree) to 4 (strongly agree). Each scale is scored out of 28. A high score indicates greater role clarity. Reliability and validity have been established. Comparable data are available from Onyett *et al.*'s (1997) study of CMHTs. Factor analysis in Onyett *et al.*'s (1997) study lead to an abbreviated form of the personal role

clarity scale which excluded questions 1, 3 and 5. In the current study these items were not used in the calculation of the personal role clarity scale. Internal reliability was 0.79 for the *personal role clarity scale* and 0.85 for the *team role clarity scale*.

3.4.6. Questionnaire exploring background factors important in a clinical psychologist's team/ professional identification, job satisfaction and burnout. (Appendix VII)

This questionnaire was devised for the purpose of the study. The questionnaire contained 19 items exploring factors which were considered important in a clinical psychologist's team and professional identification, job satisfaction and burnout. The items were generated from the organisational psychology literature and from discussion with three clinical psychologists who were experienced in multi-disciplinary teamwork. The items generated could be grouped into the following topic areas (examples of question items are given in italics):

Integration within the team
How many days per week do you work for the team?;
Do you share an office base with the team?.

General characteristics of the clinical psychologist
How long have you worked within the team?;
How many years previous experience have you had working with other MDTs?;
In what year did you complete clinical psychology training?

Contact with clinical psychologist colleagues
Please indicate below the number of hours per week (to the nearest 15 minutes) you spend with other psychologists.

Demographic information
age; sex; number of dependants and marital status.

Space was provided at the end of the questionnaire for qualitative comments in which. participants were asked if they had any views on the role of clinical psychologists in

MDTs. This questionnaire was devised to collect descriptive information and was not intended to be scored. Although validity and reliability was unknown, the measure was piloted, as described in *section 3.6*, and participants responded clearly.

3.5. Ethical Approval

The B.P.S. Code of Conduct (1997) was used as a guide to consider ethical issues in the current study. The main ethical issues centred around the consent and anonymity of participants. Informed consent was indicated by the return of a consent form. Care was taken to avoid the identification of participants in the communication of the results and subsequent write up. Participants were also given feedback from the study. Application for ethical approval was made to the Salomons Centre panel for ethical approval and was subsequently obtained (Appendix VIII).

3.6. Piloting of the Measures

Five clinical psychologists who worked within MDTs were approached and asked if they would participate in the pilot stage of the study. The pilot sample consisted of psychologists who worked in different specialisms and possessed a range of experience. Each participant was given a copy of the introductory letter describing the aims of the research, a consent form and a pack comprising the measures described above.

Participants in the pilot phase were also given a separate sheet (Appendix IX) on which to comment upon the following aspects of the questionnaire: the clarity of the instructions; the clarity of layout and presentation; the readability, relevance and clarity of specific items; and the length of the questionnaire.

In response to the feedback several minor changes were made to items on the Background Information section of the questionnaire. Several items were excluded whereas others were expanded. Although two pilot participants commented upon the length of the questionnaire they also said that it was "interesting" and "thought provoking" to complete. The responses of those participants in the pilot study were also included in the analysis of the main sample.

3.7. PROCEDURE

Potential participants were identified as described in *Section 3.3*. Each of the 208 identified clinical psychologists was contacted via a letter outlining the aims and the voluntary nature of participation in the research (Appendix X). Informed consent from participants was obtained from the front page consent form (Appendix XI). In addition they were sent a number of measures which are described in *Section 3.4*. They were also sent a request form for a copy of the outcome of the study (Appendix XII), and a form to complete if they did not wish to participate (Appendix XIII).

All participants were sent a pack comprising of the introductory letter and the measures listed below, presented in the following order:

1. Introductory letter outlining the aims and voluntary nature of participation in the study
2. Background information sheet
3. Team Climate Inventory (TCI)
4. Personal/Team Role Clarity scales
5. Job Satisfaction Scale ("How you feel about your job")
6. Maslach Burnout Inventory (MBI)
7. Team/Professional identification scales
8. Consent Form
9. Request form for copy of outcome of the study
10 Form to complete if they did not wish to participate.

Participants were required to complete the measures and return them in the pre-paid envelope provided. Participants were asked to indicate if they wished to receive feedback from the main findings of the study. Upon completion of the research, participants received the main findings and a print out of their own scores, to compare against the means of the main sample.

3.8. Data Management

Data was analysed using SPSS for windows (1995). The one sample Kolmogorov-Smirov procedure was used to test the hypothesis that the sample came from a population in which the variable was normally distributed (Appendix XIV). The results indicated that the following variables were not normally distributed: *professional identification*; *team identification*; *depersonalisation*; *satisfaction with achievement, value and growth*; *satisfaction with organisational processes*; and all *team climate* variables. The remaining variables were normally distributed. Visual inspection of histograms for each variable confirmed these findings (Appendix XV).

It was deemed useful to compare the current sample with other available research. The one sample t-test was used to explore differences in scores of the current sample and other groups. Although this is a parametric test it was selected as there was not a non-parametric equivalent, and median scores were not available from the research literature. Given that some of the variables in the current study were not normally distributed these findings should be interpreted with a degree of caution.

The remainder of the analysis incorporated some variables which were not normally

distributed, therefore non-parametric tests were used, enabling consistency in the presentation of results. Relationships between variables were explored using Spearman's correlation co-efficient. Differences between groups were analysed using Kruskall-Wallis Anova and the Mann-Whitney U statistic. For exploratory data analysis, differences between groups were analysed using the parametric independent t statistic only where the test variable was proven to be normally distributed. Table 3 provides a summary of the analysis used for each hypothesis described in *Section 2.2.*

All hypotheses were two-tailed, given that significant results found in either direction would be of interest (MacRae, 1995). The probability levels given in each analysis, throughout the results section, are expressed as two tailed probabilities. Due to the large number of statistical tests conducted, and the strong possibility of Type 1 errors, the significance level was set at $p<.01$. Correlation co-efficients were interpreted using the significance level and Cohen and Holliday's (1982) guide. A coefficient between 0.7 and 0.89 is considered a "high" correlation, between 0.40 and 0.69 is considered a "modest" correlation, and between 0.2 and 0.39 is considered a "low" correlation. (Cohen & Holliday, 1982).

Table 3. Summary of statistical analysis for each hypothesis.

Hypothesis*	Statistical test used
1	Wilcoxon Signed Ranks Test
2	Spearman's Correlation Co-efficient
3	Spearman's Correlation Co-efficient
4.1 -4.5	Spearman's Correlation Co-efficient
5	Kruskall-Wallis and Mann-Whitney
6	Spearman's Correlation Co-efficient
7.1-7.8	Kruskall-Wallis, Mann-Whitney or Independent t statistic

*See Section 2.2 for a full description of the hypotheses.

4. RESULTS

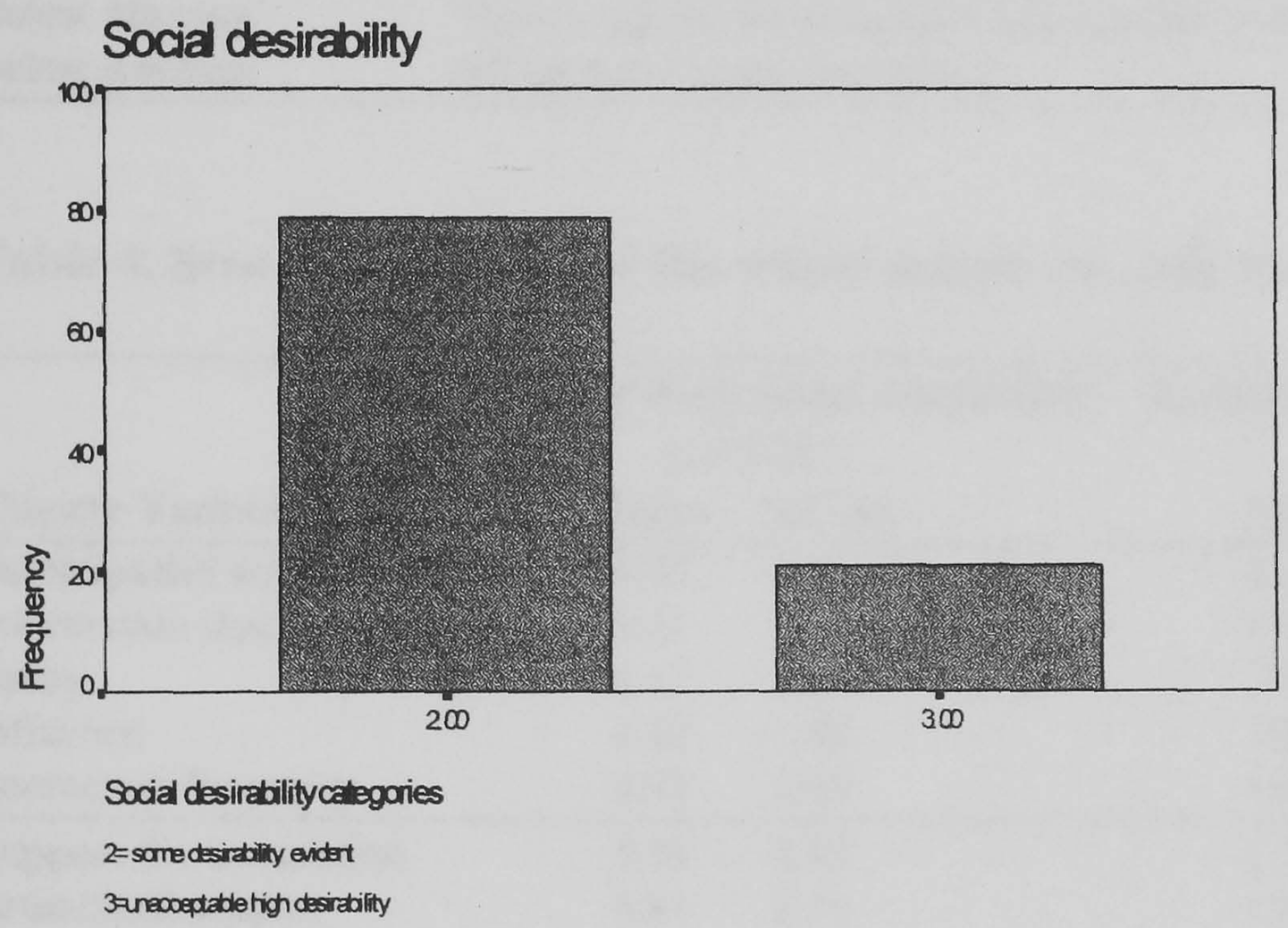
The scores on each main variable, for participants in the current study, are presented and compared with data available from similar samples. Each research hypothesis is then described, and the statistical analysis and key findings are presented. This is followed by a summary of the main findings from the research.

4.1. Current Sample Compared With Other Groups.

4.1.1. Team Climate Inventory (TCI)

The findings for social desirability sub-scale are presented first. Figure 1 illustrates the proportion of psychologists displaying high, moderate and low levels of social desirability.

Figure 1. Social desirability scores on the TCI.



The current sample displayed high levels of social desirability; 21 participants (21%) had unacceptably high levels of social desirability while none of the sample displayed acceptable low levels of social desirability. Recent correspondence with one of the scale authors (Prof. Michael West) suggests that experience of using the scale indicates that

high social desirability scores reflect a positive "general affective tone" towards the team rather than necessarily an attempt to create a falsely positive impression.

Table 4 summarises the mean responses of clinical psychologists on the key dimensions comprising West's (1990) four-factor theory of climate. Responses are represented as 'sten' scores based upon the norms derived from a study of 20 psychiatric teams. Means and standard deviations are also provided for the sample after participants with unacceptably high levels of social desirability have been excluded. The sten scores can be interpreted in the following way:

8th sten and above **Above average**	The team is functioning well in this area but the team procedures should continue to be monitored and evaluated
4th sten-7th sten **Average**	There is room for improvement on this aspect of team functioning. Particular team building interventions are likely to be beneficial.
Below 4th sten **Below Average**	There is a need for structured and intensive intervention to redress this aspect of team functioning.

Table 4. Sten score means for the whole sample on each team climate variable.

	Including High Social desirability (n=108)		**Excluding High social desirability (n=79)**	
Climate Variable	Mean	Std Dev	Mean	Std Dev
Participative safety	5.50	2.22	5.17	1.79
Information sharing	6.11	2.17	6.08	1.88
Safety	4.17	2.19	3.78	1.78
Influence	4.10	1.96	3.84	1.62
Interaction frequency	6.78	2.63	6.60	2.48
Support for innovation	5.59	2.93	5.23	2.63
Articulated support	4.81	2.71	4.63	2.36
Enacted Support	6.51	3.09	6.33	2.94
Vision	5.09	2.09	4.81	1.74
Clarity	5.93	2.57	5.70	2.32
Perceived value	5.14	2.51	5.00	2.39
Sharedness	4.09	1.77	3.87	1.48
Attainability	5.37	2.28	5.40	2.26
Task Orientation	4.29	2.11	4.15	1.93
Excellence	4.94	2.72	4.80	2.75
Appraisal	3.15	1.86	3.05	1.59
Ideation	5.06	2.45	4.84	2.26

Table 5 below, depicts the percentage of psychologists in the current sample who perceived aspects of team climate as *below average*, *average*, and *above average* based upon TCI norms for psychiatric teams. The main observation from Table 5 is the high proportion of psychologists who perceived some of the climate factors as *below average*.

Table 5. Percentage distribution of psychologists scoring below average, average and above average on aspects of team climate (not excluding high social desirability)

Climate Variable	Below Average (below 4th sten)	Average (4th-7th sten)	Above average (8th sten and above)
Participative safety	14.3	65.7	20
Information sharing	12.1	58	29.9
Safety	48.1	39.8	12.1
Influence	45.8	49.5	4.7
Interaction frequency	19	26.7	54.3
Support for innovation	32.4	27.6	40
Articulated support	42.5	31.1	26.5
Enacted Support	24.5	26.5	49.1
Vision	26	58.7	15.4
Clarity	15.3	43.8	41
Perceived value	40.4	37.5	22
Sharedness	50.1	45.2	4.8
Attainability	23.1	47.1	29.8
Task Orientation	42	49.6	8.4
Excellence	37.1	38.9	24.1
Appraisal	71	25.2	3.8
Ideation	25	55.6	19.5

For *safety* and *influence*, 48.1% and 45.8% of psychologists respectively, were in the below average category. A low scale score on the *safety* factor indicated that psychologists perceived team members "as less ready to try out new ideas, and less likely to risk appearing foolish". A low scale score on the *influence* factor indicated that psychologists perceived "the process of decision making as carried out less collectively than most teams".

For *perceived value* and *sharedness*, 40.4% and 50.1% of psychologists respectively, perceived these climate factors as below average. A low scale score on the *perceived value* factor indicated that the psychologist regarded team "objectives as less worthwhile and clear than other teams". A low score on the *sharedness* factor indicated that psychologists felt that there were "lower than average levels of agreement about the teams objectives" .

For *task orientation* and *appraisal*, 42% and 71% of psychologists respectively perceived these team climate as below average. A low scale score on *task orientation* factor indicated that psychologists felt that "team members were less likely than average to critically reflect upon the appropriateness of various aspects of their tasks". A low score on the *appraisal* factor indicated that psychologists perceived that "team members infrequently monitored or critically appraised each other".

Finally 42.5% of psychologists scored in the below average category for *articulated support*. A low scale score indicates that psychologists perceived that "innovative activity was verbally encouraged less than in other teams".

4.1.2. Burnout

Table 6 depicts the mean scores and standard deviations on each burnout variable for the current sample. Table 7 shows the distribution of burnout of the current sample in terms of high/medium/low, based upon the top, middle and bottom third of the distribution used for the MBI scale norms.

Table 6. Mean Burnout scores for whole psychology sample.

Variable	Mean	S D	Median	Range	n
Depersonalisation	4.73	3.83	4.00	0 - 20	107
Emotional Exhaustion	20.43	9.06	20.00	0 - 52	106
Personal Accomplishment	37.63	4.65	38.00	24 - 47	101

Table 7. Percentage of sample falling into "high", "medium" and "low" categories of burnout based upon norms for mental health workers (Maslach & Jackson, 1986)

	High	Medium	Low
Depersonalisation	19.6	21.5	58.9
Emotional Exhaustion	46.2	28.3	25.5
Personal accomplishment	75.9	16.7	0.9

One sample t-tests were used to compare the means of the current sample with available comparative data. Table 8 illustrates differences between the current sample and Maslach and Jackson's (1986) sample of 730 mental health workers comprising psychologists, psychotherapists, counsellors and psychiatrists. Significant differences ($p<.001$) were found on all burnout variables. The current sample experienced more *emotional exhaustion* and greater feelings of *personal accomplishment*, but less *depersonalisation* compared with Maslach and Jackson's (1986) sample.

Table 8. Mean Burnout scores for whole psychology sample compared with Maslach and Johnson's (1986) sample of mental health workers.

Variable	Mean	Maslach mean	Mean Diff	Value of t	n	2-tailed significance
Depersonalisation	4.73	5.72	-.99	-2.67	107	<.001***
Emotional Exhaustion	20.43	16.89	3.54	4.03	106	<.001***
Personal Accomplishment	37.63	30.87	6.76	14.63	101	<.001***

***p<.05, **p<.01, ***p<.001.**

Table 9 illustrates differences between the current sample and Onyett *et al.*'s (1997)

sample of clinical psychologists (n=36). There were no significant differences on the *depersonalisation* and *emotional exhaustion* scales, however the current sample had greater *personal accomplishment* ($p<.05$) than Onyett *et al.*'s (1997) sample.

Table 9. Mean Burnout scores for whole psychology sample compared with Onyett *et al.*'s (1997) sample of clinical psychologists (n=36).

Variable	Mean	Onyett mean	Mean difference	Value of t	n	2-tailed significance
Depersonalisation	4.73	5.1	-.37	-1.00	107	.319 NS
Emotional Exhaustion	20.43	20.6	-.17	-.19	106	.851 NS
Personal Accomplishment	37.63	36.7	.93	2.02	101	.046 *

***p<.05, **p<.01, ***p<.001.**

4.1.3. Job Satisfaction

Table 10 describes the mean scores and standard deviations for the current sample on each of the job satisfaction variables from Cooper *et al.*'s (1988) job satisfaction scale. One sample t-tests were used to compare means of the current sample with available comparative data.

Table 10. Mean level of job satisfaction of the current sample.

VARIABLE	Mean	SD	Median	Range	n
Achievement, value growth	24.96	5.63	26.00	11- 36	107
Job itself	17.70	2.82	18.00	9 - 24	107
Organisational design & structure	18.56	4.38	19.00	8 - 28	107
Organisational processes	17.69	3.24	18.00	9 - 24	102
Personal relationship	12.64	2.95	13.00	4 -18	108
Total satisfaction	91.24	16.05	91.00	60 -126	99

Table 11 illustrates differences between the current sample and Cooper *et al.*'s (1992) sample which included norms for 'professions allied to medicine' including psychologists.

Significant differences ($p < .001$) were found on most variables. The current sample were more satisfied with all aspects of job satisfaction, although this was less for *personal work relationships* ($p<.05$).

Table 11. Mean job satisfaction of psychology sample compared with Cooper and Rees (1992) study of job satisfaction in health service workers.

VARIABLE	Mean	Cooper Mean	Mean difference	Value of t	n	2 tailed significance
Achievement, value growth	24.96	21.34	3.62	6.65	107	<.001 ***
Job itself	17.70	16.38	1.32	4.85	107	<.001 ***
Organisational design & structure	18.56	17.27	1.29	3.05	107	.003 **
Organisational processes	17.69	15.81	1.88	5.85	102	<.001 ***
Personal work relationships	12.64	11.92	0.72	2.53	108	.013 *
Total satisfaction	91.24	82.73	8.51	5.28	99	<.001 ***

***p<.05, **p<.01, ***p<.001.**

Table 12 illustrates differences between the current sample and Onyett *et al.*'s (1997) sample of clinical psychologists. The current sample were more satisfied with the *job itself* ($p<.001$) and the *organisational design and structure* ($p<.05$).

Table 12. Mean job satisfaction of psychology sample compared with Onyett *et al.*'s (1997) sample of clinical psychologists.

VARIABLE	Mean	Onyett Mean	Mean difference	Value of t	n	2 tailed significance
Achievement, value growth	24.96	24.3	0.66	1.22	107	.226 NS
Job itself	17.70	16.21	1.49	5.47	107	<.001 ***
Organisational design and structure	18.56	17.7	0.86	2.03	107	.045 *
Organisational processes	17.69	17.2	0.49	1.52	102	.133 NS
Personal work relationships	12.64	13	-0.36	-1.27	108	.206 NS
Total satisfaction	91.24	88.1	3.14	1.95	99	.054 NS

***p<.05, **p<.01, ***p<.001.**

4.1.4. Team and Professional Identification

Table 13 shows the mean and standard deviations for the current sample on the *professional identification* and *team identification* scales. One sample t-tests were used to compare the means of the current sample with clinical psychologists in Onyett *et al.*'s (1997) study (Table 14). Psychologists in the current sample had a higher *professional identification* ($p<.001$), but similar levels of *team identification*, compared with Onyett *et al.*'s (1997) sample of clinical psychologists.

Table 13. Team and Professional identification means for the whole sample.

	Mean	SD	Median	Range	n
Team Identification	25.93	6.30	28.00	6 - 32	107
Professional Identification	28.49	4.43	30.00	11 - 32	108

Table 14. Team and Professional identification means compared with Onyett *et al.*'s (1997) sample of clinical psychologists.

	Mean	Onyett Mean	Mean difference	Value of t	n	2-tail sig
Team Identification	25.93	25	0.93	1.52	107	.131 NS
Professional Identification	28.49	26.8	1.69	3.97	108	<.001 ***

***p<.05, **p<.01, ***p<.001.**

4.1.5. Personal and team role clarity

Table 15 describes the means and standard deviations for the *personal* and *team role clarity* scales. One sample t-tests indicated that there were significant differences between the current sample and Onyett *et al.*'s (1997) sample. Psychologists in the current sample had higher personal and team role clarity (Table 16).

Table 15. Team/Personal role clarity means for the whole sample.

	Mean	SD	Median	Range	n
Personal RC	11.05	3.77	12.00	1-16	108
Team RC	16.37	6.38	16.50	1 -28	108

Table 16. Team/Personal Role Clarity means compared with Onyett *et al.*'s (1997) sample of clinical psychologists.

	Mean	Onyett Mean	Mean difference	Value of t	n	2-tail sig
Personal Role Clarity	11.05	9.4	1.65	4.54	108	<.001 ***
Team Role Clarity	16.37	15.1	1.27	2.07	108	.041 *

***p<.05, **p<.01, ***p<.001.**

4.2. *Hypothesis 1*: H_1 Clinical psychologist's professional identification will be significantly higher than their level of team identification.

Professional identification scores ranged from 11-32, with a median of 30. *Team identification* scores ranged from 6-32 with a median of 28. Clinical psychologists had a higher *professional identification* than *team identification*. A Wilcoxon signed rank test indicated that the difference between *professional* and *team identification* was significant ($z = -3.88$, $p<.0001$), indicating significantly higher professional identification than team identification, enabling the acceptance of the predictive hypothesis.

Analysis using Spearman's correlation coefficient was conducted to determine if *professional identification* was related to *team identification*. The results suggested that *professional identification* and *team identification* were not associated ($r=.041$, $n= 107$, $p=.677$ NS).

4.3. *Hypothesis 2*: H_1 A high team identification will be associated with high job satisfaction and low burnout.

Spearman's correlation co-efficient was used to explore the relationship between *team identification*, *job satisfaction* and *burnout.* The correlation matrix is shown in Table17.

Team identification was positively and modestly associated with the following aspects of job satisfaction: *total job satisfaction* (r= .601, n=98, p<.001); *satisfaction with work relationships* (r= .690, n=107, p<.001); and *satisfaction with organisational design and structure* (r=.603, p<.001). Team identification was not significantly correlated with burnout. The predictive hypothesis was therefore only partially accepted.

Table 17. Spearman's correlation coefficients for team identification and burnout and job satisfaction.

	Team id	MBI-dep	MBI-ee	MBI-pacc
MBI- Depersonalisation	-.041			
MBI- Emotional exhaustion	-.141			
MBI- Personal accomplishment	.082			
Total job satisfaction	.601**	-.195	-.346**	.304*
satisfaction job itself	.400**	-.153	-.423**	.242
satisfaction organisational design	.603**	-.158	-.283*	.287*
satisfaction organisational process	.434**	-.123	-.314**	.159
satisfaction work relationships	.690**	-.069	-.202	.244
satisfaction achievement, value	.431**	-.169	-.314**	.244

*p<.01, **p<.001

KEY: Team id= team identification; MBI-Dep=depersonalisation; MBI-ee= emotional exhaustion; MBI-pacc=personal accomplishment.

4.4. *Hypothesis 3*: H_1 High personal role clarity and high team role clarity will be associated with high team identification, high job satisfaction and low burnout.

Spearman's correlation co-efficient was used to explore the relationship between *role clarity* and the following measures: *team identification*; *job satisfaction*; and *burnout.* The correlation matrix is shown in Table 18.

Personal role clarity was positively and modestly correlated with *team role clarity* (r=.582, n=108, p<.001) and *satisfaction with organisational design* (r=.480, n=107, p<.001). *Personal role clarity* was negatively and modestly correlated with *emotional exhaustion* (r=-.408, n=106, p<.001). Low positive associations with personal role clarity were found for *satisfaction with work relationships* (r=.383, n=108, p<.001); *total job satisfaction* (r=.384, n=99, p<.001) and *team identification* (r=.273, n=107, p<.01).

Team role clarity was positively and modestly associated with *team identification* (r=.462, n=107, p<.001); *total job satisfaction* (r=.446, n=99, p<.001); *satisfaction with the organisational design* (r=.583, n=107, p<.001); and *satisfaction with work relationships* (r=.505, n=108, p<.001). Team role clarity was not associated with burnout.

The predictive hypothesis with respect to both team and personal role clarity was only partially accepted.

Table 18. Spearman's correlation coefficients for role clarity, identification, burnout and job satisfaction

	SPEARMANS r	
	Personal RC	**Team RC**
Team RC	.582**	
Team identification	.273*	.462**
Satisfaction total	.384**	.446**
Satis_Achievement	.328*	.297*
Satis_Job itself	.343**	.354**
Satis_OrganDesign	.480**	.583**
Satis_OrgProcesses	.251	.318*
Satis_Relations	.383**	.505**
Depersonalisation	.173	-.100
Emotional Exhaustion	-.408**	-.152
Personal Accomplishment	.193	.027

*p<.01; **p<.001. Key: Personal RC=personal role clarity; Team RC=team role clarity.

4.5. *Hypotheses 4.1 -4.5* :

*** Clinical psychologists who have a greater length of experience working in MDTs will have higher team identification.**
*** Clinical psychologists who have worked for a greater length of time within their current team will have higher team identification.**
*** Clinical psychologists who work a greater number of sessions per week with the team will have higher team identification.**

*** Clinical psychologists who have greater experience within the profession will have higher professional identification.**
*** Clinical psychologists who have a greater amount of contact with other psychologists will have higher professional identification.**

Spearman's correlation co-efficient was used to explore the relationship between the above variables and *team identification* and *professional identification*. Surprisingly, the amount of MDT experience, the number of sessions worked with the team, and length of time with the current team, were not significantly correlated with *team identification.* In addition, amount of contact with other psychologists was not significantly associated with *professional identification.* The correlation co-efficients are displayed in Table 19. None of the correlation coefficients were significant beyond $p<.01$, and correlation co-efficients were low. The predictive hypotheses was therefore all rejected.

Table 19. Spearman's correlation coefficients for team identification, professional identification and independent variables.

Independent variable	Pro Ident	Team Ident
Time with current team	-.117	.026
Total MDT experience	-.014	.089
Years Qualified as psychologist	.063	-.034
Number sessions in team	-.225	-.011
Contact (Dept Meetings)	.117	-.207
Contact (Informal)	.077	.045
Contact (supervision given)	.004	.028
Contact (supervision received)	-.082	.092

Key: Pro Ident=professional identification; Team Ident=team identification;

A further exploratory analysis, was used to see if *personal* and *team role clarity* was associated with the following independent variables: time with current team; level of experience as a psychologist; number of sessions worked in the team; and amount of MDT experience. No significant associations were found (Appendix XVI).

4.6. *Hypothesis 5: H_1* Clinical psychologists with both "high" team and "high" professional identification will have greater job satisfaction and lower burnout compared with other groups.

Participants were coded as "high" or "low" on team identification and professional identification using a split around the median (see Appendix XVII). Participants were coded within a two by two probability table as "high" on both variables, "low" on both variables, or "high" on one variable and "low" on the other.

Non-parametric tests were chosen to explore differences between the four groups as the sample size in each group was small and evidence for any distributional assumption was not available empirically. Table 20 depicts the results of a Kruskal -Walls one way analysis of variance between the four groups.

No significant differences were found between the four groups on any of the burnout variables, however there were significant differences on the job satisfaction variables. A series of Mann Whitney statistics were used to identify which groups demonstrated significant differences (Table 21). Psychologists with "high" team identification in combination with "high" or "low" professional identification had significantly higher job satisfaction than the remaining two groups. The predictive hypothesis was only partially accepted.

Table 20. Significant differences between groups coded as high or low on team identification (TI) and professional identification (PI) using Kruskal-Wallis.

OUTCOME VARIABLE	GROUP *a*	MEDIAN	RANGE	TEST STATISTIC	SIG
Depersonalisation	HighTI / High PI	4	0-12	KW= 4.90	0.18 NS
	High TI / Low PI	6	0-18		
	Low TI / High PI	3	0-10		
	Low TI / Low PI	6	0-20		
Emotional Exhaustion	HighTI / High PI	18	0-31	KW= 7.63	0.54 NS
	High TI / Low PI	21	3-52		
	Low TI / High PI	19	9-45		
	Low TI / Low PI	26	13-34		
Personal Accomplishment	HighTI / High PI	38	31-47	KW= 0.53	0.91 NS
	High TI / Low PI	38	31-45		
	Low TI / High PI	36	24-45		
	Low TI / Low PI	38	30-46		
Job satisfaction total	HighTI / High PI	100	63-120	KW= 27.62	**
	High TI / Low PI	102	78-126		
	Low TI / High PI	87	60-113		
	Low TI / Low PI	80	63-105		
Satisfaction achievement, value & growth	HighTI / High PI	27	15-36	KW=15.55	*
	High TI / Low PI	28.5	17-35		
	Low TI / High PI	22.5	13-32		
	Low TI / Low PI	22	11-29		
Satisfaction Job itself	HighTI / High PI	17	11-21	KW=15.26	**
	High TI / Low PI	19	9-24		
	Low TI / High PI	19	11-21		
	Low TI / Low PI	16	13-22		
Satisfaction Organisation Design	HighTI / High PI	21	10-25	KW=33.98	**
	High TI / Low PI	22.5	16-28		
	Low TI / High PI	17	8-22		
	Low TI / Low PI	15.5	9-23		
Satisfaction organisational processes	HighTI / High PI	19.5	11-23	KW=18.94	**
	High TI / Low PI	19	12-24		
	Low TI / High PI	17.5	12-13		
	Low TI / Low PI	15.5	9-21		
Satisfaction personal work relationships	HighTI / High PI	13.5	10-17	KW=42.87	**
	High TI / Low PI	16	10-18		
	Low TI / High PI	11.5	4-16		
	Low TI / Low PI	11	5-15		

*p< .01; **p<.001

KEY: High TI / High PI = high team identification & high professional identification; High TI / Low PI = high team identification & low professional identification; Low TI / High PI = low team identification & high professional identification; Low TI / Low PI = low team identification & low professional identification.

***a* = GROUP SIZES**: High TI / High PI=32; High TI / Low PI=24; Low TI / High PI=25; Low TI / High PI=25.

Table 21. Multiple comparison between groups for job satisfaction using Mann Whitney statistic.

VARIABLE	Significant differences between groups.
Job Satisfaction total	High TI-High PI >Low TI-Low PI**, Low TI-High PI** High TI-Low PI >Low TI-Low PI**, Low TI-High PI*
Satis. with achievement value & growth	High TI-High PI >Low TI-Low PI* High TI-Low PI >Low TI-Low PI**
Satis. with organisational processes	High TI-High PI >Low TI-Low PI** High TI-Low PI >Low TI-Low PI**
Satis. with job itself	High TI-High PI >Low TI-Low PI* High TI-Low PI >Low TI-Low PI**
Satis. with personal relationships	High TI-High PI >Low TI-Low PI**, Low TI-High PI**, High TI-Low PI* High TI-Low PI >Low TI-Low PI**, Low TI-High PI**
Satis. with organisational design & structure	High TI-High PI >Low TI-Low PI**, Low TI-High PI* High TI-Low PI >Low TI-Low PI**, Low TI-High PI**

*p=<.01; **p=<.001.

1 Using the Bonferroni adjustment, to reduce the likelihood of Type 1 errors, the probability level was reduced from 0.05 to 0.01, only probabilities of below 0.01 are regarded as significant.

4.7. *Hypothesis 6: H_1* A high positive team climate will be associated with high team identification, high job satisfaction and low burnout.

Table 22 reports Spearman's correlation co-efficients for team climate with burnout and team identification. No significant relationship was found between *team climate* and *burnout*, although low, but statistically significant associations were found for *emotional exhaustion* and *support for innovation* (r=.258, p<.01), and *emotional exhaustion* and *attainability* (r=.263, p<.01).

Aspects of *team climate* were significantly and positively associated with *team*

identification. Although there were many interpretable findings, modest co-efficients were found for *participative safety* (r=.606, p<.001), *task orientation* (r=.618, p<.001), *support for innovation* (r=.560, p<.001) and *influence* (r=.512, p<.001).

Table 22. Spearman's Correlation Coefficients for aspects of team climate, burnout and team identification.

CLIMATE FACTOR	EME	PACC	DEP	TEAM ID
Articulated Support	-.243	.205	-.151	.510**
Enacted Support	-.248	.058	-.183	.554**
Information Sharing	-.134	.051	-.068	.428**
Influence	-.165	.136	-.091	.512**
Interaction Frequency	-.021	-.054	-.043	.544**
Safety	.004	.009	-.039	.638**
Clarity	-.209	.119	-.122	.200
Perceived Value	-.193	.015	-.068	.460**
Sharedness	-.147	-.031	-.131	.314**
Attainability	-.263*	.070	-.077	.382**
Ideation	-.107	.110	.030	.645**
Appraisal	-.103	.115	-.082	.527**
Excellence	-.042	.154	.011	.456**
Support for Innovation	-.258*	.143	-.187	.560**
Participative Safety	-.106	.026	-.076	.607**
Task Orientation	-.104	.161	-.038	.618**
Vision	-.230	.090	-.098	.380**

*p<.01, **p<.001.
KEY: EME=Emotional Exhaustion; PACC=Personal Accomplishment; DEP=Depersonalisation; TEAM ID=Team Identification.

Table 23 describes correlation coefficients for team climate and job satisfaction.

Team climate was significantly and positively associated with job satisfaction. In particular, modest correlation co-efficients were found between *total job satisfaction* and the following climate factors: *support for innovation* (r=.627, p=<.001), *participative safety* (r=.611, p<.001), and *task orientation* (r=.601, p<.001). The predictive hypothesis was only partially accepted.

Table 23. Spearman's correlation coefficients for climate factors and job satisfaction variables.

CLIMATE FACTOR	SATISFACTION VARIABLE					
	TOT	ACHI	ODS	JOBI	OPRO	PREL
Articulated Support	.620**	.509**	.687**	.506**	.477**	.510**
Enacted Support	.573**	.423**	.666**	.443**	.395**	.577**
Information Sharing	.509**	.299*	.623**	.377**	.417**	.542**
Influence	.562**	.419**	.607**	.439**	.493**	.596**
Interaction Freq	.465**	.293**	.532**	.248	.408**	.464**
Safety	.457**	.247*	.601**	.286*	.371**	.631**
Clarity	.355**	.158	.482**	.246	.260**	.407**
Perceived Value	.521**	.421**	.566**	.298*	.426**	.505**
Sharedness	.396**	.173	.543**	.238	.335**	.438**
Attainability	.354**	.236	.394**	.280*	.273*	.335**
Ideation	.628**	.499**	.672**	.453**	.460**	.622**
Appraisal	.551**	.513**	.585**	.395**	.376**	.534**
Excellence	.387**	.226	.494**	.305*	.255**	.476**
Support Innovation	.627**	.488**	.722**	.506**	.456**	.616**
Participative Safety	.602**	.391**	.702**	.401**	.518**	.641**
Task Orientation	.601**	.499**	.679**	.458**	.401**	.625**
Vision	.472**	.299*	.605**	.311**	.374**	.501**

***p<.01, **p<.001.**

KEY: TOT=Total satisfaction; ACHI=satisfaction with achievement, value and growth; ODS= satisfaction with organisational design; JOBI=satisfaction with job itself; OPRO=satisfaction with organisational processes; PREL=satisfaction with personal relationships.

4.8. Exploratory Data Analysis.

4.8.1. Gender.

Hypothesis 7.1: H_1 **Female clinical psychologists will have higher burnout than male psychologists.**

Analysis revealed no significant difference between males and females on any of the *burnout* variables (*emotional exhaustion*: t=-1.01, n=106, p<.317 NS). The predictive hypothesis was rejected.

4.8.2. Dependants.

Hypothesis 7.2: H_1 **Clinical psychologists with dependants will have higher burnout than those psychologists without dependants.**

A significant difference on levels of emotional exhaustion was found between

psychologists who had dependants and those who did not (t=-3.11, n=98, p<.01).

Surprisingly, psychologists without dependants had higher levels of emotional exhaustion.

The predictive hypothesis was therefore not confirmed.

4.8.3. Leadership role.

Hypothesis 7.3: H_1 **Clinical psychologists who hold a leadership role within the team will have higher levels of team identification and job satisfaction, and lower burnout than psychologists who do not hold a leadership role.**

No significant difference for team identification was found between psychologists who held a leadership role in the MDT and those who did not (z=-1.08; p=.2807 NS).

There were also no significant differences in levels of emotional exhaustion (t=-1.34, n=105, p=.184 NS). Further analysis revealed that psychologists with a leadership role had greater *job satisfaction* (t=4.20, n=98, p<.01) and *team role clarity* (t=3.70, n=107, p<.001). The predictive hypothesis was partially accepted.

4.8.4. Office base

Hypothesis 7.4 : H_1 **Clinical psychologists who have an office base with the team will have higher levels of team identification than those psychologists who do not have an office base with the team.**

A larger proportion of the sample had an office base with the team (n=85). A significant difference was found between psychologists who had an office base with the team and those who did not on levels of team identification, allowing acceptance of the predictive hypothesis (z=-2.75, p<.01).

4.8.5. Frequency of team meetings.

Hypothesis 7.5 : H_1 **Clinical psychologists who are members of teams which meet frequently will have higher levels of team identification than psychologists who are members of teams which meet less frequently.**

There were no significant differences in team identification between teams which met very

frequently (e.g. twice a week) and those which met less often (e.g. once a fortnight),

leading to the rejection of the predictive hypothesis (KW=0.08, not significant).

4.8.6. Psychologist alone in speciality.

Hypothesis 7.6 : H_1 **Clinical psychologists who work alone in a speciality will have higher burnout, lower job satisfaction and lower professional identification than psychologists who do not work alone in a speciality.**

No differences were found on any of the outcome measures for psychologists who worked alone in their speciality and those where there were other psychologists. The predictive hypothesis was therefore rejected.

4.8.7. Psychologist alone in team.

Hypothesis 7.7 : H_1 **Clinical psychologists who are the only psychologist in the team will have lower professional identification, lower job satisfaction and higher burnout than psychologists who are not the only psychologist.**

No difference was found between those psychologists who were the only psychologist in the team and where there were other psychologists in the same team. The predictive hypothesis was therefore rejected.

4.8.8 Speciality

Hypothesis 7.8 : H_1 **Clinical psychologists working in learning disability or rehabilitation will have higher team identification than psychologists working in other specialities.**

A Kruskal-Wallis one way analysis of variance was used to explore differences between *specialities* and the measures. With the exception of *team identification* (KW=11.47, $p<.05$), no significant differences were identified. Further exploratory analyses using Mann-Whitney revealed that the main differences in team identification were between psychologists in adult mental health and those in child/family teams, with the latter

demonstrating higher team identification (z=-2.82, p<.01)[1]. The predictive hypothesis was therefore rejected.

4.9. What comments did the sample have regarding the role of clinical psychologists within MDTs?

Responses varied with many participants not directly answering the question. 65.7% of the sample took the opportunity to comment. Written comments were analysed using content analysis (Oppenheim, 1992). Comments were condensed into 9 categories depicting the key issues for psychologists within MDTs. Table 24 highlights the number and percentage of comments relating to each of the 9 major categories identified. Each category comprised of comments which were positive and negative. Examples of comments in each category are presented.

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[1] Using the Bonferroni adjustment, to reduce the likelyhood of Type 1 errors, the probability level was reduced from 0.05 to 0.01, only probabilities of below 0.01 are regarded as significant.

Table 24. Categories and examples from content analysis.

CATEGORY	N (%)	EXAMPLE
1. Genericism; inability to use a range of psychological skills; role unrecognised.	**17 (15.6)**	Difference in role is a big issue, there seems to be quite a pressure to "all do the same".
2. Conflict with medical model; relationship with consultant.	**14 (12.8)**	The problem with this team is a clear reticence to accommodate other models/ approaches other than a medical/diagnostic one.
3. Importance of professional identification: contact with psychology colleagues; departmental meetings; CPD.	**19 (17.4)**	It is important to maintain a clear professional identity through CPD, belonging to a department etc., otherwise psychological thinking may be lost.
4. Conflict with team members regarding personal role.	**11 (10.1)**	We are sometimes seen as "elitist" and "lazy" because we develop a role in teaching and consultation as well as direct work.
5. Clarity of team objectives; purpose; role; values.	**12 (11)**	I'm not sure that "team" is the right word for these loose collection of workers. It seems very difficult to achieve a real team identity or sense of purpose.
6. Expansion of personal role: leadership; consultancy; specialist; advisor.	**6 (5.5)**	Teams fare much better when the team leader is a psychologist....There should be incentives for psychologists to head teams.
7. Role to promote teamwork; sort out difficulties (experienced as positive or negative)	**3 (2.8)**	There are several personality clashes within the team.....There seems to be an expectation psychology (me) can fix this which provides added pressure
8. Feel role is valued and accepted within the team.	**5 (4.6)**	I feel very valued by my team.
9. Unclassifiable.	**22 (20.2)**	Need to be confident and competent to function well in MDTs.

Inter-rater reliability was assessed using Cohen's Kappa (Kappa value= 0.79; $p<.0001$).

4.10. SUMMARY OF MAIN FINDINGS

1. The TCI indicated that many psychologists perceived team climate as low on the following aspects: involvement in decision making; safety; agreement about objectives; perceived value of objectives; reflection upon the task; critical appraisal and monitoring of each other; and verbal encouragement of innovative activity.

Clinical Psychologists experienced significantly higher *emotional exhaustion*, higher *personal accomplishment*, and lower *depersonalisation* compared with MBI norms (Maslach & Jackson, 1986).

Clinical Psychologists were significantly more satisfied with aspects of their work compared with norms based upon a range health professions (Cooper *et al* , 1992) This difference was not as significant for *satisfaction with work relationships*.

2. *Professional identification* was significantly higher than *team identification.* *Team identification* and *professional identification* were not associated.

3. *Team identification* was significantly and modestly associated with aspects of *job satisfaction*, but was not significantly associated with *burnout*. There was a low, but significant, association between *emotional exhaustion* and aspects of *job satisfaction.*

4. *Personal role clarity* was positively and modestly correlated with *team role clarity*, *satisfaction with organisational design* and *emotional exhaustion. Team role clarity* was positively and modestly correlated with *team identification*, aspects of job satisfaction including *organisational design* and *personal work relationships*, but not burnout.

5. Number of sessions worked with the team, amount of MDT experience, amount of time with current team, and total experience as a clinical psychologist, were not significantly associated with *team* or *professional identification.* Amount of contact with other clinical psychologists was not associated with *professional identification.*

6. The predictive hypothesis that there would be a difference, on levels of job satisfaction

and burnout, between clinical psychologists with both "high" team and "high" professional identification and other groups, was partially accepted. Psychologists who maintained a "high" team identification with either "high" or "low" professional identification had significantly higher job satisfaction than those with low team identification. There was no difference in levels of burnout.

7. Aspects of team climate were not significantly correlated with burnout. However, aspects of team climate were significantly associated with team identification (particularly: participative safety; support for innovation; influence; task orientation). Team climate was strongly correlated with aspects of job satisfaction.

8. There was no significant difference between male and female psychologists in levels of burnout. Psychologists without dependants had higher levels of emotional exhaustion. Where the psychologist was team leader, he/she had greater satisfaction and team role clarity. Psychologists having an office base with the team had greater team identification. No differences were found between speciality and any of the dependent variables, except team identification. Psychologists working in child and family teams had greater team identification than psychologists in adult mental health.

5. DISCUSSION

The main findings from the study are discussed in relation to the research literature. The methodological weaknesses and strengths of the study are reviewed, and implications for future research are discussed. The implications of the findings for services and clinical practice are presented.

5.1. Discussion of the main findings

5.1.1. Team and Professional Identification

In common with Onyett *et al.*'s (1997) sample of clinical psychologists, the current sample had a higher professional identification than team identification. Although there was a significant difference between professional and team identification, team identification remained relatively high. The majority (89.7%) of participants' scores were above the mid-point of the team identification scale, and a large proportion (64.5%) were in the top quarter. This contrasts with the literature where psychologists are presented as having low team identification (Onyett *et al.*, 1997; Sainsbury Centre, 1997), and probably reflects a different emphasis in how findings have been reported. In Onyett *et al.*'s (1997) study, psychologists' team identification was found to be lower than that of other professions, but still relatively high. Team identification for psychologists in Onyett *et al.*'s study was not significantly different from that of the current sample. In conclusion, clinical psychologists maintain a positive team identification, be it lower than that of other professions.

Having an office base with the team seemed an important factor in achieving a high team

identification. This finding supports Cushway and Lodge's (1993) assertion that sharing base with the team, facilitates interaction and co-operation between team members, leading to increased team identification.

The results indicated no relationship between the number of sessions worked in the team and team identification. This implied that a high team identification did not necessarily require full-time MDT membership, which contrasts with commentators who argue that greater full-time commitment of team members would lead to a stronger team identity (Onyett *et al.* 1997). Surprisingly, neither frequency of team meetings, nor length of time in the team were associated with team identification. This finding contrasts with Roberts (1997) and Brown *et al.* (1986) who suggested that increased contact with team members over a period of time, would result in greater team identification. Presumably this would be the case within a team functioning effectively, but not necessarily so within a dysfunctional team.

There was limited evidence to support the social identification prediction, that a team member's ability to balance their professional and team memberships would lead to effective team performance and better outcomes for team members, including job satisfaction and burnout. Burnout was not associated with team identification. The current study indicated that "high" team identification, in combination with either "high" or "low" professional identification, resulted in high job satisfaction. The results suggested that a positive identification with the team was more important for a clinical psychologist's job satisfaction than identification with the profession. This may reflect the fact that psychologists on the whole, spend more of their time with the team rather than with other

psychologists.

The findings indicated several ways in which team identification and possibly job satisfaction could be enhanced. Firstly, team identification was positively and modestly associated with team role clarity, suggesting that a psychologist who is clear about the team objectives and purpose, may experience greater team identification. This finding supported Cushway and Lodge (1993) who suggested that clear team aims lead to greater commitment, a sense of common purpose and a positive team identification.

Secondly, team climate was also a variable which was positively associated with team identification. In particular, modest associations were found between team identification and: *safety*; *ideation*; *enacted support*; *interaction frequency* and *influence*. Enhancing these aspects of team climate may facilitate team identification. West and Anderson (1994) suggested some possible interventions to increase these aspects of team climate: for *safety*, they recommended an interpersonal process review; for *interaction frequency*, an interaction audit and review of formal team meetings; for *influence*, a review of the decision making process; for *ideation*, the use of brainstorming techniques; and for *enacted support*, a review of time, finance and co-operation for innovation within the team.

Professional identification was not associated with contact with other clinical psychologists as predicted (Brown *et al.*,1986). Neither was the presence of other clinical psychologists in the team or speciality associated with a high professional identification. This was a surprising finding, considering the proportion of psychologists (17.5%) who

spontaneously commented on the importance of a strong professional identification through contact with other psychologists. This finding may be a reflection on how contact with colleagues was assessed in the study, and is discussed later. It may also suggest that the nature of the contact, and feeling valued by other members of the profession, is equally if not more important than amount of contact per se. Although the current study found no association, contact with psychology colleagues may still be an important factor in professional identification and should not be discounted.

5.1.2. Team Climate

Team climate was not only associated with team identification but was also related to job satisfaction, a finding which corresponds to previous research (e.g. Jackovsky & Slocum, 1988).

The TCI indicated that clinical psychologists perceived the team climate as low on a number of aspects, in particular: *safety* (48.1%), *appraisal* (71%) and *sharedness* (50.1%). Qualitative feedback from participants in the study also supported these findings. The team climate results validated some of the criticisms voiced by commentators on MDTs (Searle, 1991; Galvin & McCarthy, 1994; Alexander, 1992; Sheppard, 1996).

Safety as previously discussed, is important for creativity in teams. Qualitative responses within the study indicated that psychologists perceived the team climate as one of competition and mistrust. A number of participants referred to 'envy' of the psychologist's role by other disciplines, and 'professional insecurity'; such factors may contribute to the

lack of safety and are clearly demonstrated below:

"CPNs are often expected to carry a heavier caseload, process referrals faster and {they} begrudge psychologists their 'precious' approach to their work"

"I think doctors are threatened by us and nurses can be envious as we may be perceived as working with higher status patients"

A climate of safety may be achieved when team members are clear about their respective roles, relationships and responsibilities within teams, and where team managers facilitate openness. As a consequence, individuals may feel more ready to challenge team members and take risks in collaborative work. Individuals who feel unsafe are less likely to critically appraise each others work. This may explain the high proportion of psychologists scoring low on the *appraisal* aspect. One participant commented: *"It is difficult to challenge the team and introduce new ways of working".*

The extent to which the goals of the team were shared by team members was also perceived as low, confirming the literature on MDTs (Galvin & McCarthy, 1994). In the current study, one participant commented *"It seems very difficult to achieve a real team identity or consensus about team purpose".* A frequent issue regarding team purpose, and particularly salient in adult mental health teams, was agreement about which client group the team would prioritise. One participant commented: "*Level one work (primary care) is not valued or recognised within this MDT set-up".* These findings indicated the need for the review and clarification of team goals and purpose.

The current study explored psychologists' perceptions of team climate and not the

collective impression of team members. Correspondence with one of the test authors (Professor West) indicated that focusing upon an individual within a team was an acceptable use of the TCI. Further research is needed to establish whether the perceptions of psychologists regarding team climate are shared by other professional members of MDTs, or whether psychologists view of climate is unique. In addition, it was not clear the extent to which the timing of the current study impacted upon participants' responses to the team climate inventory. Team climate is not a static variable, but one that constantly alters over time in response to changes; at the time of data collection there was considerable reorganisation within the South Thames region, with a number of trust mergers taking place with associated uncertainty and anxiety among staff groups.

5.1.3. Burnout and Job Satisfaction

Clinical psychologists experienced a high sense of personal accomplishment and a low sense of depersonalisation compared with MBI norms, a pattern similar to that of psychologists in Onyett *et al.*'s (1997) study. Emotional exhaustion was reported by many clinical psychologists in the study. An alarming 46.2% of the sample fell into the "high" emotional exhaustion category (based upon MBI norms for mental health workers). This figure was comparable with Carson *et al.*'s (1995) study of CPNs in which 48% experienced 'high' emotional exhaustion, but higher than the 41.2% for clinical psychologists reported in Onyett *et al.*'s (1997) study. Co-variation in emotional exhaustion, personal accomplishment and depersonalisation challenges the conceptualisation of burnout as a syndrome, (Maslach & Jackson,1986), in which individuals experience both high emotional exhaustion and depersonalisation, with low

personal accomplishment.

Emotional exhaustion was associated with low clarity regarding the psychologist's personal role in the team. This finding is supported by research of burnout in CPNs, which found that poor role clarity and role ambiguity were associated with emotional exhaustion (Melchior *et al.*, 1997; Firth *et al.*, 1987). A greater understanding of personal role within the team may lead to a decrease in emotional exhaustion.

Burnout was not associated with team climate. This was an unexpected finding, as team climate factors such as support and involvement in decision making, have previously been associated with burnout in psychiatric nurses (e.g. Sullivan, 1993). Many of the psychologists in the sample worked part-time within MDTs, and aspects of their role outside of the team may have contributed to emotional exhaustion. Emotional exhaustion was positively associated with some aspects of job satisfaction, specifically satisfaction regarding the *job itself.* This finding suggests that burnout was more likely to be the product of the nature of the work rather than factors related to the organisation or team-working. No differences were found between psychologists working in different specialities.

In contrast to previous research with psychiatric nurses (Schaufeli, 1990), there was no effect of gender on burnout in clinical psychologists. Interestingly however, psychologists who had dependants experienced less emotional exhaustion. Although other variables such as age and experience may have confounded this finding, it suggests that psychologists with dependants were able to achieve a equal balance between work

and home-life. This finding may also reflect differences between psychologists who worked full-time overall (including work outside of the team) and those who worked part-time overall. This information was not available but could have been obtained in the current study. The Maslach Burnout Inventory assessed burnout at work and therefore did not pick-up home related stress.

Overall job satisfaction, in the current sample was significantly higher than that reported by Rees and Cooper (1992), and similar to that reported for the smaller number of clinical psychologists in Onyett *et al.*'s (1997) study. Farber (1983) reports that the co-existence of burnout and job satisfaction is not unusual. A high level of work commitment is regarded as a prerequisite to burnout and is more likely to occur with high levels of job satisfaction (Farber, 1983).

5.2. Methodological Critique

The response rate (52.2%) was relatively high given that the study was a postal survey and reflected the effectiveness of the methodology and recruitment of participants. It also indicated the salience and perceived relevance of the study for psychologists working within teams.

One concern of the current study was the extent to which the findings could be generalised to other clinical psychologists working within teams. Those who responded and completed questionnaires may have had a more positive or negative perception of team work. A further limitation was the correlational design of the study which did not enable one to draw any conclusions regarding the causal relationship between variables.

The issue of validity was an important issue in the current study. A weakness of the study concerned the validity in part, of the Questionnaire devised to explore background factors relating to team/professional identification, burnout and job satisfaction. Participants were asked to estimate the amount of time per week they spent with other psychologists which may not have been a reliable way to obtain an estimate of contact with other psychologists. It might have been useful to explore the nature of contact with other psychologists, and identify the relative value of each.

Item 14, regarding the participants' perceptions of the role of the psychologist, needed to be more specific as participants tended to make subjective comments about their own teams rather than objective comments on the role of clinical psychologists in MDTs. It would have been useful for participants to describe both the rewarding and dissatisfying areas of their work. Given the number of participants who commented on item 14, the opportunity to express their opinions in a qualitative format seemed to be beneficial. Participants' responses to this question indicated that other factors may have impacted on job satisfaction and burnout. A small number (12.8%) of the sample commented upon the role of a consultant psychiatrist and conflict with the medical model. It would have been interesting to have obtained information as to the presence of a consultant psychiatrist in the team and how this related to job satisfaction.

In considering burnout, 'speciality' was not a useful way to assess the type of direct clinical work carried out by psychologists. It may have been more meaningful to have incorporated other information such as caseload size and complexity of client difficulties.

The methodological issues raised in the discussion carry a number of implications for future research. A qualitative approach would be a valuable means of exploring more fully the perceptions and understanding clinical psychologist's have, of issues relating to professional and team identification. In addition, the categories identified in the content analysis in the current study would be worth exploring further using a qualitative methodology.

The adoption of a longitudinal design would enable an understanding of the causal relationship between variables. Using such a design would also be helpful in understanding how team and professional identification could develop over time. Using a qualitative methodology, it would be possible to interview psychologist's at various stages of their career with the team, and identify the aspects important for influencing team and professional identification.

5.3. Implications for services, clinical practice and clinical training.

The findings of the current study indicated the importance of clear team objectives and clarity of personal role. They support the organisational literature, where lack of clarity regarding the team's task and personal role have been shown to result in less effective work groups, greater stress and job dis-satisfaction (Cushway & Lodge, 1993; Warr, 1987)

The implication for services is that the team objectives, based upon the needs of the client group, should be identified at the planning stage. Planners need to agree upon the team's task and identify which people can achieve the task effectively. In some circumstances the

bringing together of individuals in a MDT may not be the most effective way of achieving the task (Ovretveit, 1986). Currently many teams are assembled out of existing staff groups who are left to decide the team's purpose (e.g. Reiman, 1989). Team members should be recruited on the basis of their specific skills which match the job requirement and contribute to the achievement of the team's overall objectives. New team members should also desire to work as part of a team.

Team objectives need to be formulated, clearly defined and shared among team members. Team objectives must also be measurable to enable the team to evaluate and enhance performance (West, 1994). The team's purpose and method of achieving the objectives should to be defined within the operational policy, specifying the: aims of the team; membership; leadership; and issues of professional and team accountability. This should be reviewed on a regular basis and shared with new members of the team. The operational policy requires the investment of effort and ideas from the team, thereby maximising consensus over the value base, objectives and practice of the service (Onyett, 1992).

There are also implications for the role of clinical psychologists in MDTs. The team, the psychologist, professional and service managers must negotiate and make explicit, the role of the psychologist prior to appointment. Information regarding the client group to be seen, the allocation of referrals, time allocated for research, teaching and service development should all be specified within a job description and shared with team members. In this way, team members may understand more clearly the psychologist's role and range of skills, reducing conflict and ambiguity between professionals.

These conclusions support recent reports such as "Pulling Together" (Sainsbury Centre,1997) and "Building Bridges" (DoH, 1995), which recommended clear team objectives, and greater clarity regarding team members core/overlapping and specialist skills.

The findings have important implications for the training of clinical psychologists. Clinical psychology training has been criticised for being dominated by the "*individual practitioner* model rather than the *team player* model" (p.62) (Sainsbury Centre, 1997). Although, MDT work is covered indirectly on many pre-qualification training courses through placement experience, group-work and organisational issues, multi-disciplinary team-working needs to be given a higher profile and made more explicit. In particular, focusing upon the psychologists role, and the skills required to ensure effective participation and collaboration within teams.

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7. APPENDICES

APPENDIX I The Team Climate Inventory.

SECTION 1. TEAM CLIMATE INVENTORY

This section asks about the climate or atmosphere in your team. It asks about how people tend to work together in your team, how frequently you interact, the team's aims and objectives, and how much practical support and assistance is given towards the implementation of new and improved ways of doing things. There are no 'right' or 'wrong' answers to any of the questions - it is more important that you give an accurate and honest response to each question. Do not spend too long on any one question. First reactions are usually best. For each question consider how your team *tends in general to be* or *how you feel in general* about the climate within your team.

Please circle your chosen answers.

COMMUNICATION AND INNOVATION

		Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	We share information generally in the team rather than keeping it to ourselves.	1	2	3	4	5
2	Assistance in developing new ideas is readily available.	1	2	3	4	5
3	We all influence each other.	1	2	3	4	5
4	The team always functions to the best of its capability.	1	2	3	4	5
5	We keep in regular contact with each other.	1	2	3	4	5
6	In this team we take the time needed to develop new ideas.	1	2	3	4	5
7	People feel understood and accepted by each other.	1	2	3	4	5
8	Everyone's view is listened to, even if it is in a minority.	1	2	3	4	5
9	People in the team never feel tense with one another.	1	2	3	4	5
10	The team is open and responsive to change.	1	2	3	4	5
11	People in the team co-operate in order to help develop and apply new ideas.	1	2	3	4	5
12	Being part of this team is the most important thing at work for team members.	1	2	3	4	5
13	We have a "we are in it together" attitude.	1	2	3	4	5
14	We interact frequently.	1	2	3	4	5
15	The team is significantly better than any other in its field.	1	2	3	4	5
16	People keep each other informed about work-related issues in the team.	1	2	3	4	5
17	Members of the team provide and share resources to help in the application of new ic	1	2	3	4	5

18	There are consistently harmonious relationships between people in the team.	1	2	3	4	5
19	There is a lot of give and take.	1	2	3	4	5
20	We keep in touch with each other as a team.	1	2	3	4	5
21	People in this team are always searching for fresh, new ways of looking at problems.	1	2	3	4	5
22	The team consistently achieves the highest targets with ease.	1	2	3	4	5
23	There are real attempts to share information throughout the team.	1	2	3	4	5
24	This team is always moving towards the development of new answers.	1	2	3	4	5
25	Team members provide practical support for new ideas and their application.	1	2	3	4	5
26	Members of the team meet frequently to talk both formally and informally.	1	2	3	4	5

OBJECTIVES

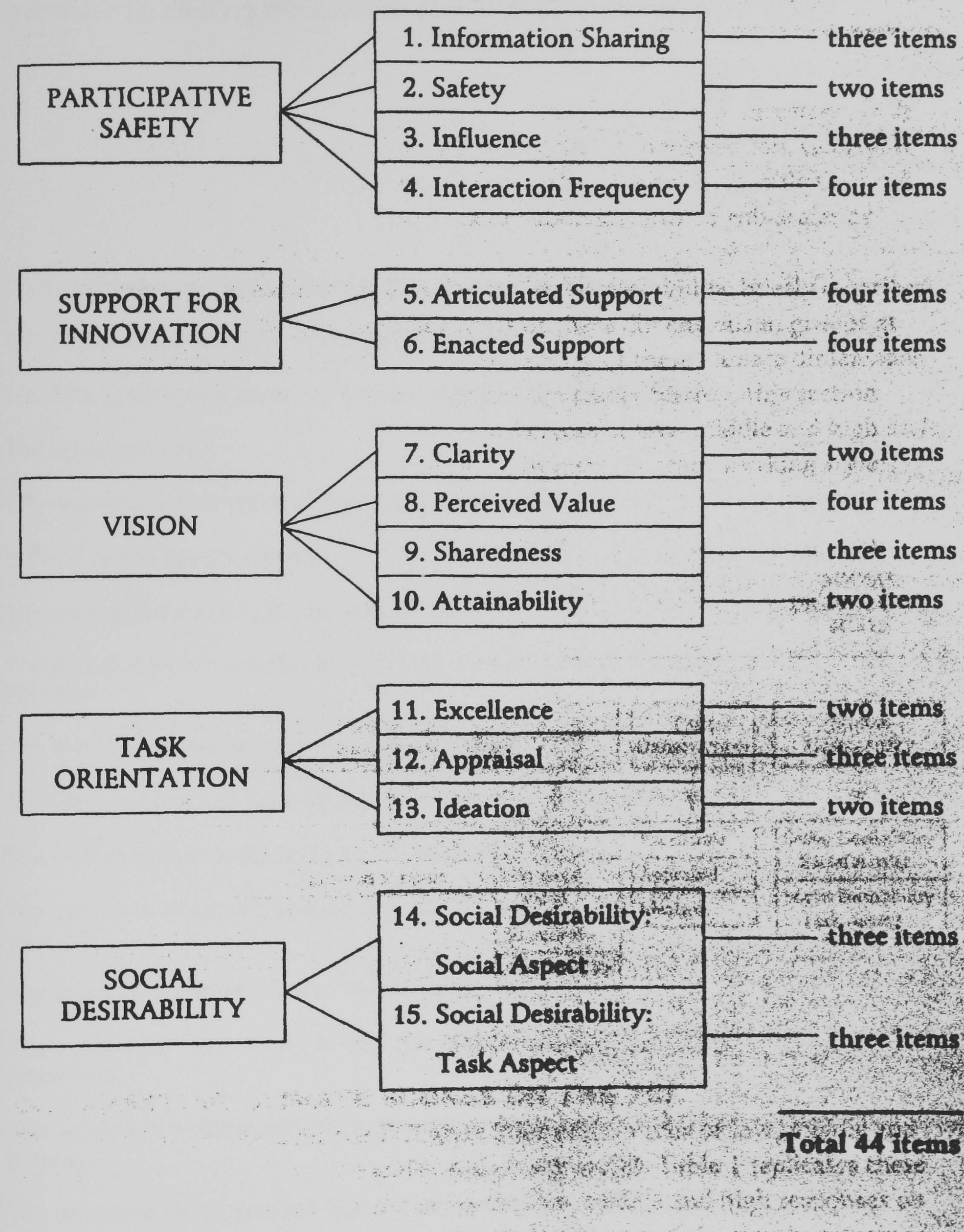
		Not at all		Somewhat		Completely
27	How clear are you about what your team objectives are?	1	2	3	4	5
28	To what extent do you think they are useful and appropriate objectives?	1	2	3	4	5
29	How far are you in agreement with these objectives?	1	2	3	4	5
30	To what extent do you think other team members agree with these objectives?	1	2	3	4	5
31	To what extent do you think your team's objectives are clearly understood by other members of the team?	1	2	3	4	5
32	To what extent do you think your team's objectives can actually be achieved?	1	2	3	4	5
33	How worthwhile do you think these objectives are to you?	1	2	3	4	5
34	How worthwhile do you think these objectives are to the organisation?	1	2	3	4	5
35	How worthwhile do you think these objectives are to the wider society?	1	2	3	4	5
36	To what extent do you feel these objectives are realistic and can be attained?	1	2	3	4	5
37	To what extent do you think members of your team are committed to these objectives?	1	2	3	4	5

TASK STYLE

		To a very little extent		To some extent		To a very great extent
38	Do your team colleagues provide useful ideas and practical help to enable you to do the job to the best of your ability?	1	2	3	4	5
39	Do you and your colleagues monitor each other so as to maintain a higher standard of work?	1	2	3	4	5
40	Are team members prepared to question the basis of what the team is doing?	1	2	3	4	5
41	Does the team critically appraise potential weaknesses in what it is doing in order to achieve the best possible outcome?	1	2	3	4	5
42	Do members of the team build on each other's ideas in order to achieve the best possible outcome?	1	2	3	4	5
43	Is there a real concern among team members that the team should achieve the highest standards of performance?	1	2	3	4	5
44	Does the team have clear criteria which team members try to meet in order to achieve excellence as a team?	1	2	3	4	5

APPENDIX II Team Climate sub-factors.

Figure 2: Structure of the 44-item TCI



APPENDIX III Occupational Stress Indicator: How you feel about your job.

SECTION 3. JOB SATISFACTION

This section looks at how satisfied you feel about your present job within the team.
The questions below are concerned with the extent to which you feel satisfied or dissatisfied with your job. Try not to be put off by any other reactions you may have - simply rate the items against the satisfaction/dissatisfaction scale provided.

Please answer by circling the number of your answer on the scale shown:

Very much satisfaction	6
Much satisfaction	5
Some satisfaction	4
Some dissatisfaction	3
Much dissatisfaction	2
Very much dissatisfaction	1

1	Communication and the way information flows around the team.	6	5	4	3	2	1
2	The relationships you have with other people at work.	6	5	4	3	2	1
3	The feeling you have about the way you and your efforts are valued.	6	5	4	3	2	1
4	The actual job itself.	6	5	4	3	2	1
5	The degree to which you feel 'motivated' by your job.	6	5	4	3	2	1
6	Current career opportunities.	6	5	4	3	2	1
7	The level of job security in your present job.	6	5	4	3	2	1
8	The extent to which you may identify with the public image or goals of the team.	6	5	4	3	2	1
9	The style of supervision that your supervisors use.	6	5	4	3	2	1
10	The way changes and innovations are implemented in the team.	6	5	4	3	2	1
11	The kind of work or tasks that you are required to perform.	6	5	4	3	2	1
12	The degree to which you feel that you can personally develop or grow in your job.	6	5	4	3	2	1
13	The way in which conflicts are resolved in the team.	6	5	4	3	2	1
14	The scope your job provides to help you achieve your aspirations and ambitions.	6	5	4	3	2	1
15	The amount of participation which you are given in important decision making.	6	5	4	3	2	1
16	The degree to which your job taps the range of skills which you feel you possess.	6	5	4	3	2	1
17	The amount of flexibility and freedom you feel you have in your job.	6	5	4	3	2	1
18	The psychological 'feel' or climate that dominates the team.	6	5	4	3	2	1
19	Your level of salary relative to your experience.	6	5	4	3	2	1
20	The design or shape of the team's structure.	6	5	4	3	2	1
21	The amount of work you are given to do whether too much or too little.	6	5	4	3	2	1
22	The degree to which you feel extended in your job.	6	5	4	3	2	1

APPENDIX IV Maslach Burnout Inventory.

SECTION 4. MASLACH BURNOUT INVENTORY

The purpose of this section is to discover how people in multi-disciplinary teams view their jobs and the people with whom they work closely.

Please read each statement carefully and decide if you ever feel this way about **your job.**

If you have **never** had this feeling, circle the '0' after the statement. If you **have** had this feeling indicate **how often** you feel it by circling the number (from 1 to 6) that best describes how frequently you feel that way.

Never	0
A few times a year or less	1
Once a month or less	2
A few times a month	3
Once a week	4
A few times a week	5
Every day	6

1	I feel emotionally drained from my work.	0	1	2	3	4	5	6
2	I feel used up at the end of the working day.	0	1	2	3	4	5	6
3	I feel tired when I get up in the morning and have to face another day at work.	0	1	2	3	4	5	6
4	I can easily understand how clients/patients feel about things.	0	1	2	3	4	5	6
5	I feel I treat some clients/patients as if they were impersonal objects.	0	1	2	3	4	5	6
6	Working with people all day is a real strain for me.	0	1	2	3	4	5	6
7	I deal effectively with the problems of clients/patients.	0	1	2	3	4	5	6
8	I feel burned out from my work.	0	1	2	3	4	5	6
9	I feel I'm positively influencing other people's lives through my work.	0	1	2	3	4	5	6
10	I've become more callous toward people since I took this job.	0	1	2	3	4	5	6
11	I worry that this job is hardening me emotionally.	0	1	2	3	4	5	6
12	I feel very energetic.	0	1	2	3	4	5	6
13	I feel frustrated by my job.	0	1	2	3	4	5	6
14	I feel I am working too hard on my job.	0	1	2	3	4	5	6
15	I don't really care what happens to some clients/patients.	0	1	2	3	4	5	6
16	Working with people directly puts too much stress on me.	0	1	2	3	4	5	6
17	I can easily create a relaxed atmosphere with clients/patients.	0	1	2	3	4	5	6
18	I feel exhilarated after working closely with clients/patients.	0	1	2	3	4	5	6
19	I have accomplished many worthwhile things in this job.	0	1	2	3	4	5	6
20	I feel I'm at the end of my tether.	0	1	2	3	4	5	6
21	In my work, I deal with emotional problems very calmly.	0	1	2	3	4	5	6
22	I feel clients/patients blame me for some of their problems.	0	1	2	3	4	5	6

APPENDIX V Team Identification and Professional Identification scales.

SECTION 5. TEAM IDENTIFICATION

This section looks at your feelings about the team.
Please answer by circling the number below:

		Strongly agree	Slightly agree	neither agree nor disagree	slightly disagree	strongly disagree
1	I feel strong ties with the team.	4	3	2	1	0
2	I don't fit in with other members of the team.	4	3	2	1	0
3	I try to hide belonging to the team.	4	3	2	1	0
4	I consider the team important to me.	4	3	2	1	0
5	I'm embarrassed to say I'm a member of the team.	4	3	2	1	0
6	I make excuses for belonging to the team.	4	3	2	1	0
7	I see myself as belonging to the team.	4	3	2	1	0
8	I'm glad to belong to the team	4	3	2	1	0

SECTION 6. PROFESSIONAL IDENTIFICATION

This section looks at your feelings about being a clinical psychologist.

Please answer by circling the number below:

		Strongly agree	Slightly agree	Neither agree nor disagree	Slightly disagree	strongly disagree
1	I'm embarrassed to say I'm a member of my profession.	4	3	2	1	0
2	I see myself as belonging to my profession.	4	3	2	1	0
3	I make excuses for belonging to my profession.	4	3	2	1	0
4	I feel strong ties with my profession.	4	3	2	1	0
5	I'm glad to belong to my profession.	4	3	2	1	0
6	I don't fit in with other members of my profession.	4	3	2	1	0
7	I consider my profession important to me.	4	3	2	1	0
8	I try to hide belonging to my profession.	4	3	2	1	0

Overall I identify most with: **(PLEASE TICK ONE BOX)**

My Profession ☐

The Team ☐

Both my profession and the team about the same ☐

Neither my profession nor the team ☐

Don't know ☐

APPENDIX VI Personal and Team Role Clarity Scale.

SECTION 2. TEAM ROLE/PERSONAL ROLE CLARITY

This section asks you to rate your agreement with various statements about your work.
Please answer by circling the number of your answer below:

		strongly agree	slightly agree	Neither agree nor disagree	Slightly disagree	Strongly disagree
1	I feel uncertain about how much authority I have.	4	3	2	1	0
2	I'm not certain of where the team's responsibilities begin and end.	4	3	2	1	0
3	I seldom know whether I'm doing my job well or poorly.	4	3	2	1	0
4	I know exactly what is expected of me.	4	3	2	1	0
5	I know what my responsibilities are.	4	3	2	1	0
6	I'm clear about who the team is trying to help.	4	3	2	1	0
7	I feel the team has a clear purpose to its work for clients/patients.	4	3	2	1	0
8	I'm not sure who I am accountable to for my work with clients/patients.	4	3	2	1	0
9	I am not certain what the team's priorities are.	4	3	2	1	0
10	I do not feel the role of the team is clearly defined.	4	3	2	1	0
11	I am clear what my work priorities are.	4	3	2	1	0
12	I know exactly what is expected of the team	4	3	2	1	0
13	I feel most of my tasks are clearly defined.	4	3	2	1	0
14	It is difficult to tell whether the team is doing its job right or not.	4	3	2	1	0

APPENDIX VII Background Information Questionnaire.

BACKGROUND INFORMATION SHEET

1. In which speciality do you work? (PLEASE TICK ONE BOX)

☐ ADULT REHAB/ CONTINUING CARE

☐ ADULT OTHER

☐ OLDER ADULT

☐ CHILD

☐ LEARNING DISABILITY

..... OTHER (PLEASE DESCRIBE)

2. Do you have a recognised leadership role with the team that involves providing leadership to more than one discipline? (e.g. as a team manager/ team leader)

YES ☐ NO ☐

3. How long have you worked within the team?

☐ YEARS ☐ MONTHS

4. Previous to this, how many years had you worked within other multi-disciplinary teams?

☐ YEARS ☐ MONTHS

5. How many days per week do you work for the team? (TO THE NEAREST HALF DAY)

☐ DAYS

6. Do you share an office base with the team? (e.g. for administrative work; where post is delivered). (PLEASE TICK ONE BOX)

☐ YES ☐ NO

7. How many people are in the team?

☐ PEOPLE

8. How often does the team have arranged meetings to formally discuss clinical work? (PLEASE TICK ONE BOX ONLY)

AT LEAST ONCE A DAY ☐

BETWEEN 2 AND 4 TIMES A WEEK ☐

ONCE A WEEK ☐

ONCE A FORTNIGHT ☐

ONCE A MONTH ☐

LESS THAN ONCE A MONTH ☐

NEVER ☐

9. Is there a team manager or a team co-ordinator?

☐ MANAGER ☐ CO-ORDINATOR ☐ NEITHER MANAGER NOR CO-ORDINATOR

CONTACT WITH OTHER CLINICAL PSYCHOLOGISTS

10. Please indicate below the number of hours per week (to the nearest 15 minutes) you spend with other psychologists.

(EXAMPLE: If the psychology department meets monthly for two hours, divide by 4 to give a weekly figure of 30 minutes)

HOURS PER WEEK (to the nearest 15 minutes)

SUPERVISION GIVEN ☐

SUPERVISION RECEIVED ☐

DEPARTMENTAL MEETINGS ☐

INFORMAL CONTACT ☐

11. Are there other psychologists who work in your speciality? (PLEASE TICK)

YES ☐ NO ☐

12. Are there other psychologists working in the team? (PLEASE TICK)

YES ☐ NO ☐

13. In what year did you complete clinical psychology training?

YEAR ☐

ADDITIONAL INFORMATION

14. Do you have any comments in relation to the role of clinical psychologists and multi-disciplinary teams? (PLEASE DESCRIBE)

.....
.....
.....

APPENDIX VIII Statement of Ethical Approval.

Salomons Centre
David Salomons Estate
Broomhill Road, Southborough
TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Facsimile: 01892 539102

Our Ref: AL/LT/075
Direct Fax: 01892 518446
E-mail: t.lavender@salomons.org.uk

SALOMONS CENTRE

Mr J Boakes
Trainee Clinical Psychologist
Salomons Centre

19th December 1997

Dear Jon,

Re: ***Ethics Approval – Jon Boakes***
"Clinical psychology and multi-disciplinary teams: An investigation into the team identification, professional identification, burnout and the job satisfaction of clinical psychologists working within multi-disciplinary teams"

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel were impressed with the thoroughness of the proposal and the way in which the ethical issues had been considered and taken into account.

There are a number of points about the research which may be worth considering. First on page 3 (section 1.1) hypothesis 3 we assumed you meant 'higher' burnout. Second, you mentioned in the text that each participant would receive feedback about their own score as well as the average scores. However, you do not say this in the consent letter and, if you did, it is the kind of thing that is likely to prove very interesting to individual psychologists and this may help to improve the response rate. Third, the National Child and Adolescent Special Interest Group has just carried out a survey of psychologists' views of working in multi-disciplinary teams and it would be worth contacting the chair of this group for information.

We wish you well with the project and would be extremely interested to see the results.

Yours sincerely,

Dr Tony Lavender
Chair of Ethics Panel

APPENDIX IX Pilot study feedback form.

QUESTIONNAIRE PILOT

1. LENGTH OF QUESTIONNAIRE:

How long did the questionnaire take to complete?

Did you feel that the time taken to complete the questionnaire was too long / too short / just right?

2. INSTRUCTIONS:

Were the instructions for the questionnaire clear and easy to understand?

3. LAYOUT AND PRESENTATION:

Was the layout and presentation clear? (If not, what needed modifying?)

4. QUESTIONS:

Which questions, if any, were ambiguous or unclear?

5. OTHER COMMENTS:

Do you have any further comments about the questionnaire?

APPENDIX X Introductory letter to participants.

Dear

I am writing to invite you to take part in the research I am conducting as part of my final year training in clinical psychology. I have identified you as a potential participant through the S. Thames Psychology Directory. In return for your support, **you will receive a report on the main findings, and a profile of your own scores**. In this way you will be able to compare your scores with those of the main sample. This report will be sent to you upon completion of the study.

The aims of my study are to investigate the experiences of clinical psychologists working with multi-disciplinary teams. There has been little research looking at the relationship between clinical psychology and teams, despite the large number of psychologists working with them. Some of the difficulties of working with teams have been highlighted within the professional literature. In the current study, I wish to explore aspects of the team structure, climate and the psychologist's role, to see how they relate to job satisfaction and burnout in psychologists. The findings may have implications for how psychologists work with teams.

I have written to all clinical psychologists in the South Thames region who work with multidisciplinary teams. Whilst I do appreciate how precious your time is, I nevertheless hope that you will be interested in participating, so that the findings will be representative of psychologist's experiences.

Included with this letter are a number of measures which, if you would like to participate I would be grateful if you could complete and return in the pre-paid envelope, **by 1st March 1998.** The questionnaire is divided into 6 sections exploring various aspects of team climate, team structure, job satisfaction and identification. Finally, I have enclosed a slip for you to complete if you would like a copy of the results. Based on a pilot of the measures, I estimate that they should take no longer than 30-40 minutes to complete. If you would like any additional information, please feel free to contact me at the above address, and I will be happy to answer any questions you may have.

Your participation is entirely voluntary, all responses will be treated in the strictest confidence and all data will be shredded once my analysis is completed. If however, you would prefer not to participate, I would be grateful if you could take a moment to complete the last sheet, which will enable me some indication as to how you reached this decision. Your brief reply would enable me to understand the decisions underlying response rates more clearly.

Thank-you for taking the time to read this letter and I hope to hear from you soon.

Yours sincerely,

Psychologist in Clinical Training.

APPENDIX XI Participant consent form.

CONSENT FORM

Title of Research Study:

Psychologists in multi-disciplinary teams: An investigation into team identification, job satisfaction and burnout in clinical psychologists.

Investigator: Jon Boakes

I (name).....
of (work address).....
.....

hereby consent to take part in the above study, the nature and purpose of which has been explained to me.

Any questions regarding the nature of this study, or its aims and method have been answered to my satisfaction.

In addition the following items have been explained to me:

1. that my anonymity will be preserved and that any information gathered from the questionnaire which could lead to my identification will be withdrawn from subsequent stages of the research.

2. I also understand that I am able to withdraw from the research at any stage, without having to explain my reason for doing so.

3. I understand that once Jon Boakes has completed his data analysis, he will shred all copies of the questionnaires.

Signed..... Date.....

APPENDIX XII Request form for a copy of the research outcome.

REQUEST FORM FOR A COPY OF THE OUTCOME OF THE STUDY

Title of Research Study:

Psychologists in multi-disciplinary teams: An investigation into team identification, job satisfaction and burnout in clinical psychologists.

Investigator: Jon Boakes

Address: Clinical Psychology Training Scheme
Salomons Centre
Broomhill Road
Southborough
Tunbridge Wells
Kent
TN3 OTG

Please send me a copy of the results of your study when you have completed your research, which I understand I will receive no later than November 1998.

Name:.....

Contact
Address.....
.....
.....

APPENDIX XIII Form for individuals who did not wish to participate.

Form detailing reasons for non-participation

If you decided not to participate please read on.....

If you decided not to participate in this study, it would be very helpful if you could take a minute to complete the form indicating what lead you to make the decision. This will give me valuable information on the way I have designed my study and enable me to gain more of an understanding about what may prevent people from taking part in a study of this nature.

Please indicate which of the following factors led you to decide not to participate:

1. Lack of interest in the area being investigated

2. Work related pressures.

3. The way the research has been designed (e.g. a quantitative study as opposed to a qualitative approach)

4. The length of the questionnaire.

5. Other (please specify; this may include any combination of the above factors).

THANKYOU FOR COMPLETING AND RETURNING THIS FORM

APPENDIX XIV Kolmogorov-Smirov test results for each main variable.

ONE SAMPLE KOLMOGOROV-SMIRNOV TEST

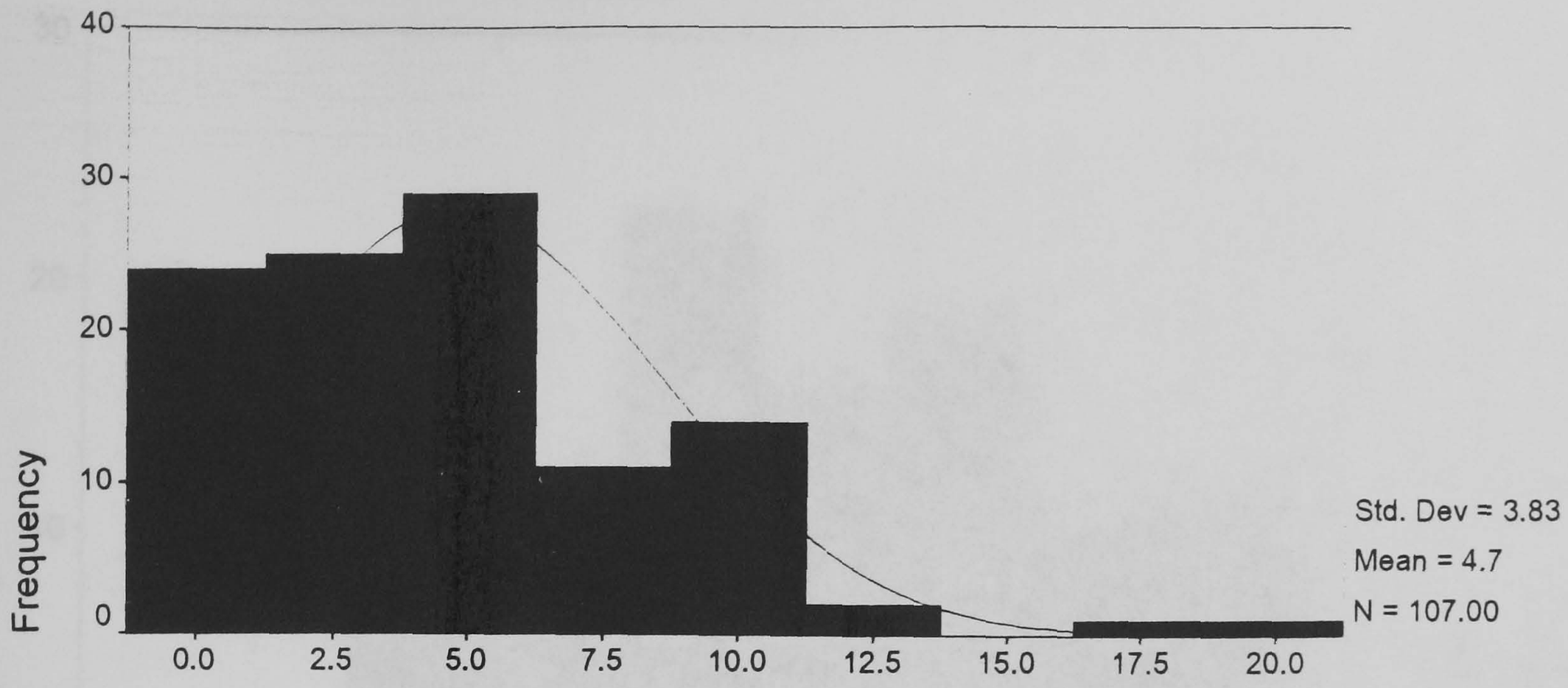
VARIABLE	K-S Z	Asymp. Sig. (2-tailed)	
Emotional Exhaustion	.909	.380	NS
Depersonalisation	**1.699**	**.006**	**
Personal Accomplishment	1.012	.257	NS
Personal Role Clarity	1.328	.059	NS
Team Role Clarity	1.085	.190	NS
Professional identification	**2.226**	**.001**	***
Team identification	**1.813**	**.003**	**
Satis. Achievement, Growth	**1.316**	**.043**	*
Satis. Job itself	.852	.463	NS
Satis. Organsation. design	1.169	.130	NS
Satis. Org. Processes	**1.380**	**.044**	*
Satis. Personal Relationships	1.084	.191	NS
Articulated Support	**1.988**	**.001**	***
Attainability	**1.821**	**.003**	**
Appraisal	**2.506**	**.001**	***
Clarity	**2.077**	**.001**	***
Enacted support	**1.812**	**.003**	**
Excellence	**1.987**	**.001**	***
Ideation	**2.311**	**.001**	***
Interaction Frequency	**2.268**	**.001**	***
Influence	**2.005**	**.001**	***
Information Sharing	**2.292**	**.001**	***
Perceived Value	**2.115**	**.001**	***
Safety	**2.144**	**.001**	***
Sharedness	**2.344**	**.001**	***
Vision	**1.925**	**.001**	***
Task Orientation	**1.870**	**.002**	**
Support for Innovation	**1.996**	**.001**	***
Participative safety	**1.948**	**.001**	***

***p<.05, **p<.01, ***p<.001.**

APPENDIX XV Distribution curves for each main variable.

Distribution of depersonalisation scores

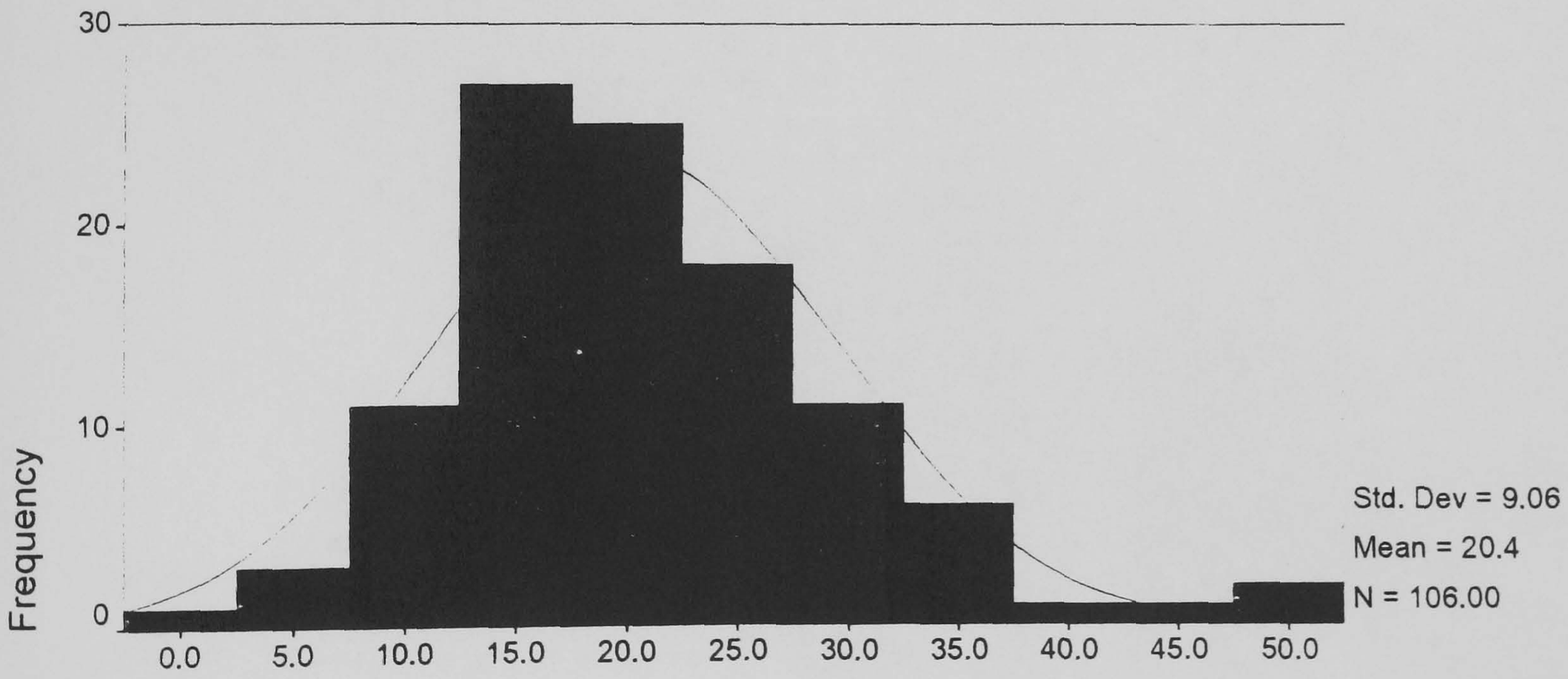
Normal curve added



MBI- Depersonalisation

Distribution of emotional exhaustion scores

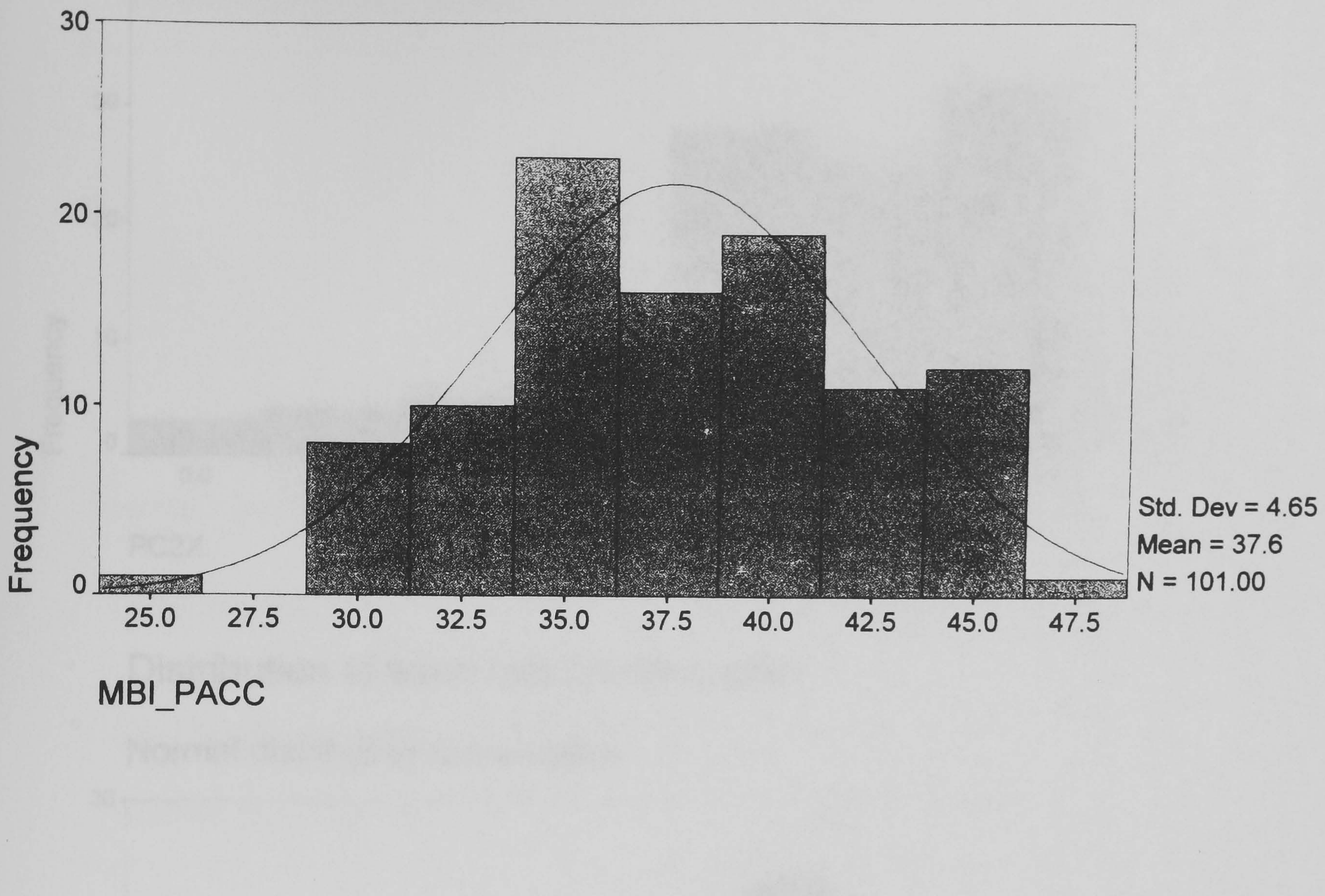
normal curve added



MBI emotional exhaustion

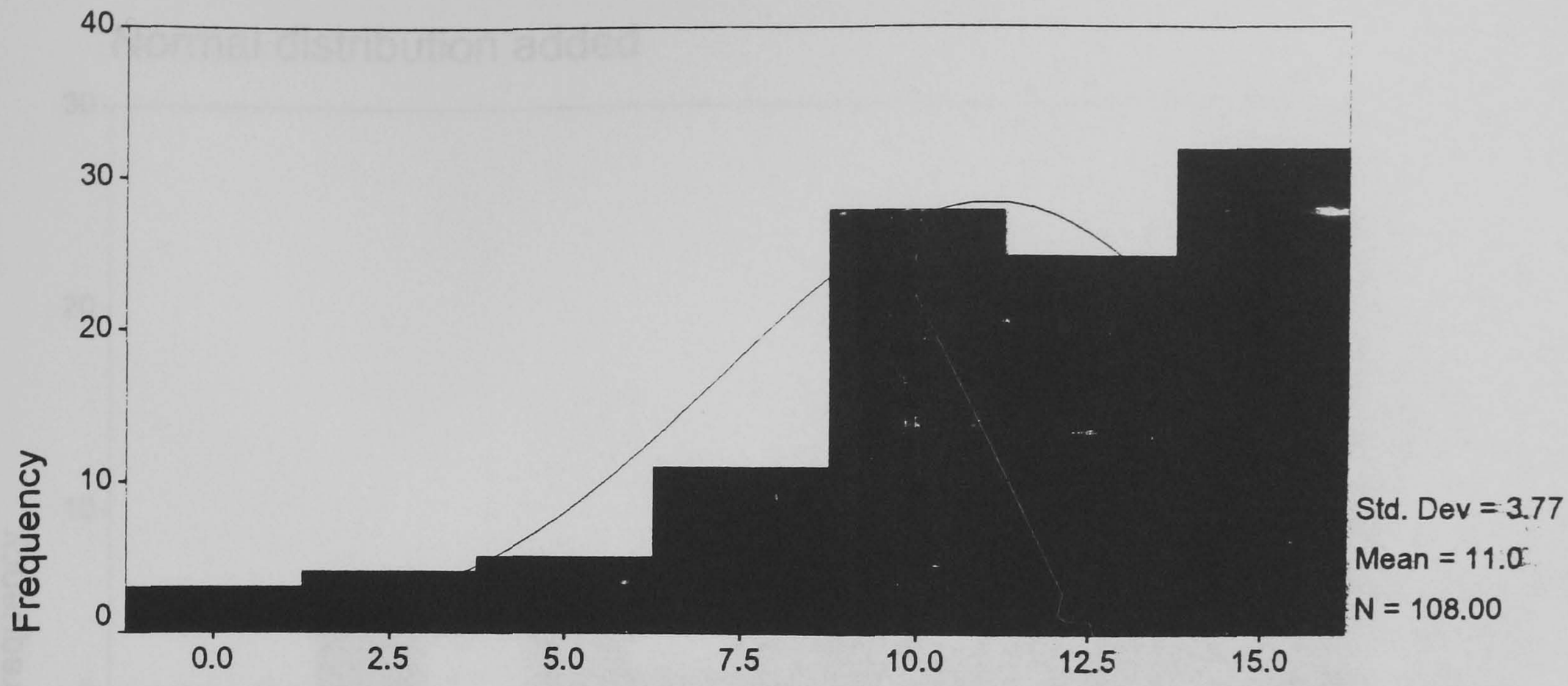
Distribution of personal accomplishment scores

Normal curve added



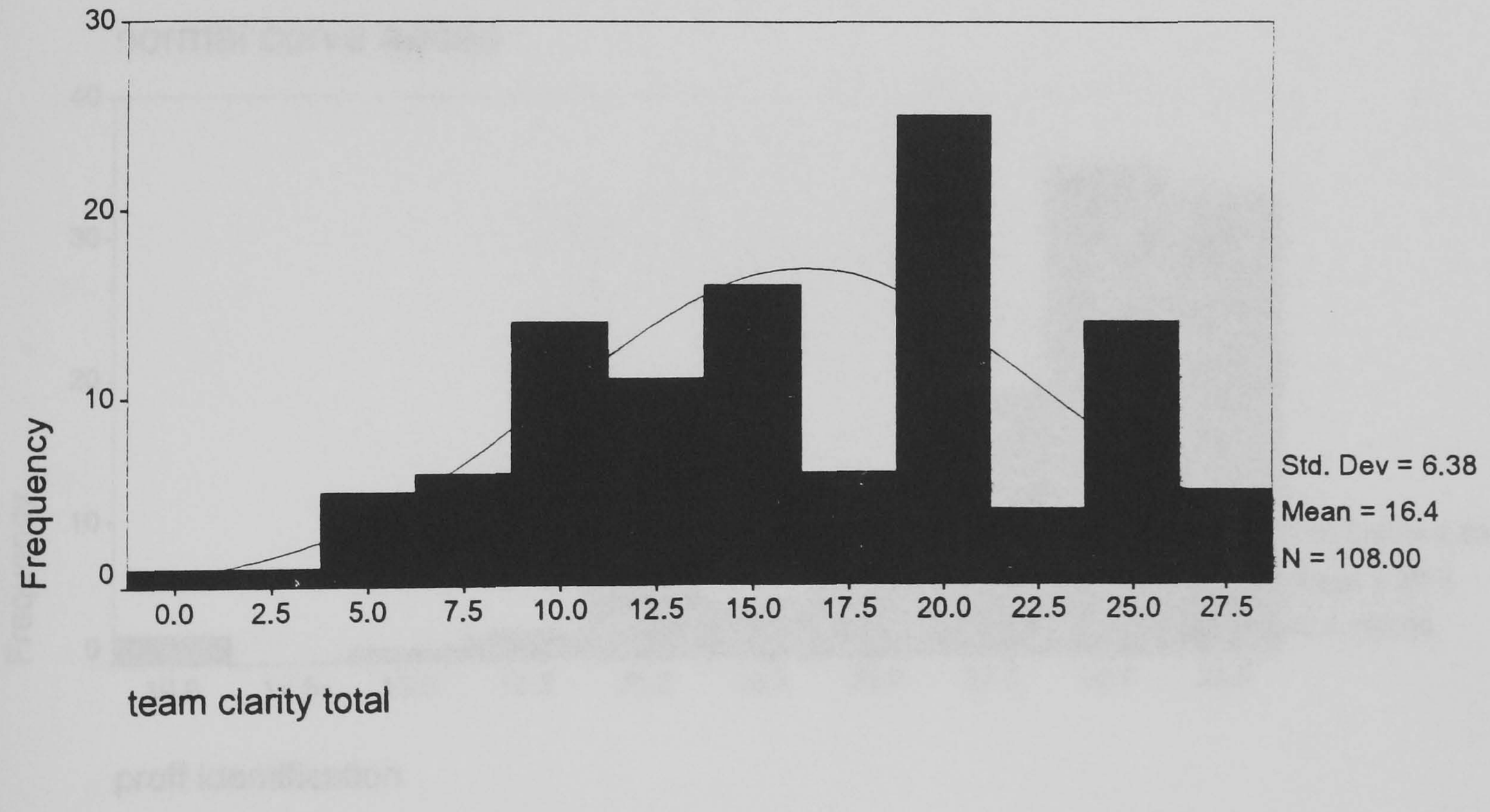
Distribution of personal role clarity scores

Normal distribution curve added



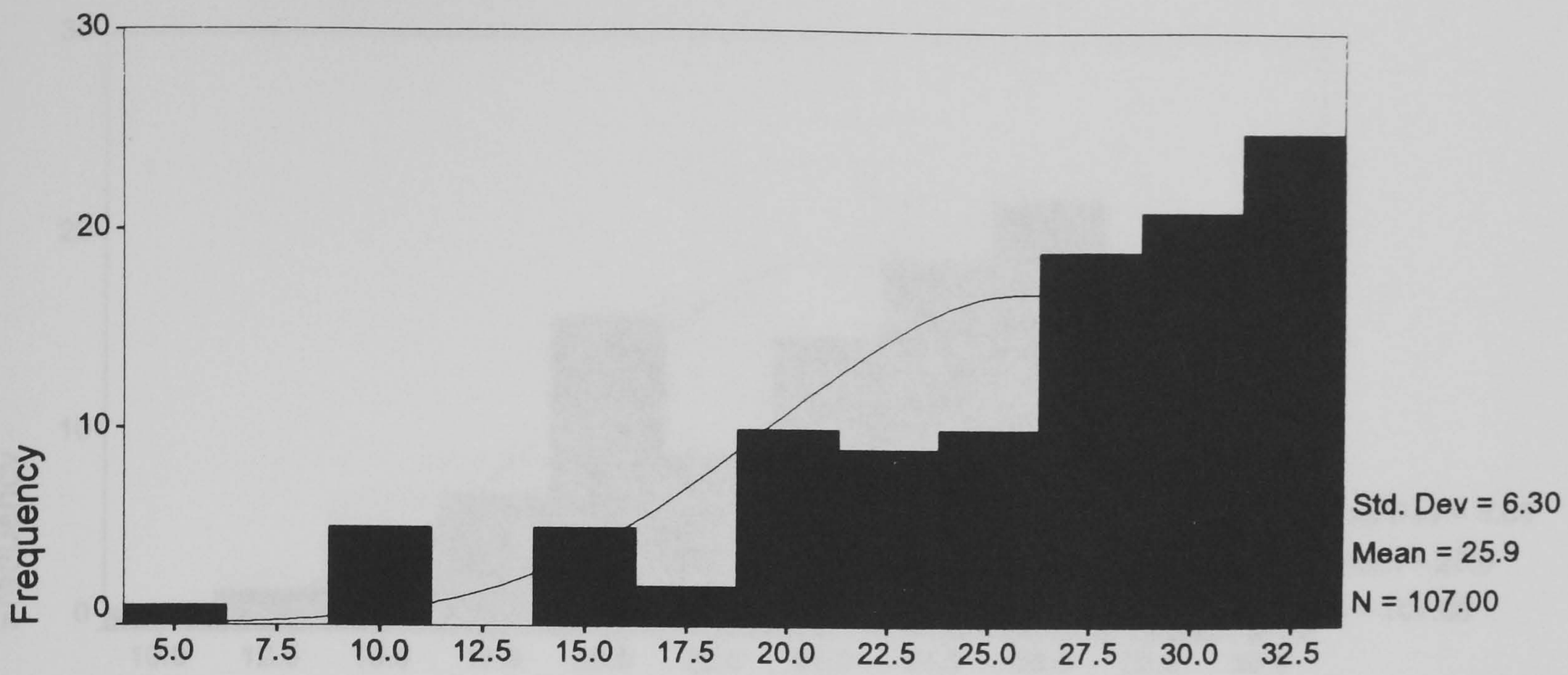
Distribution of team role clarity scores

Normal distribution curve added



Distribution of team identification scores

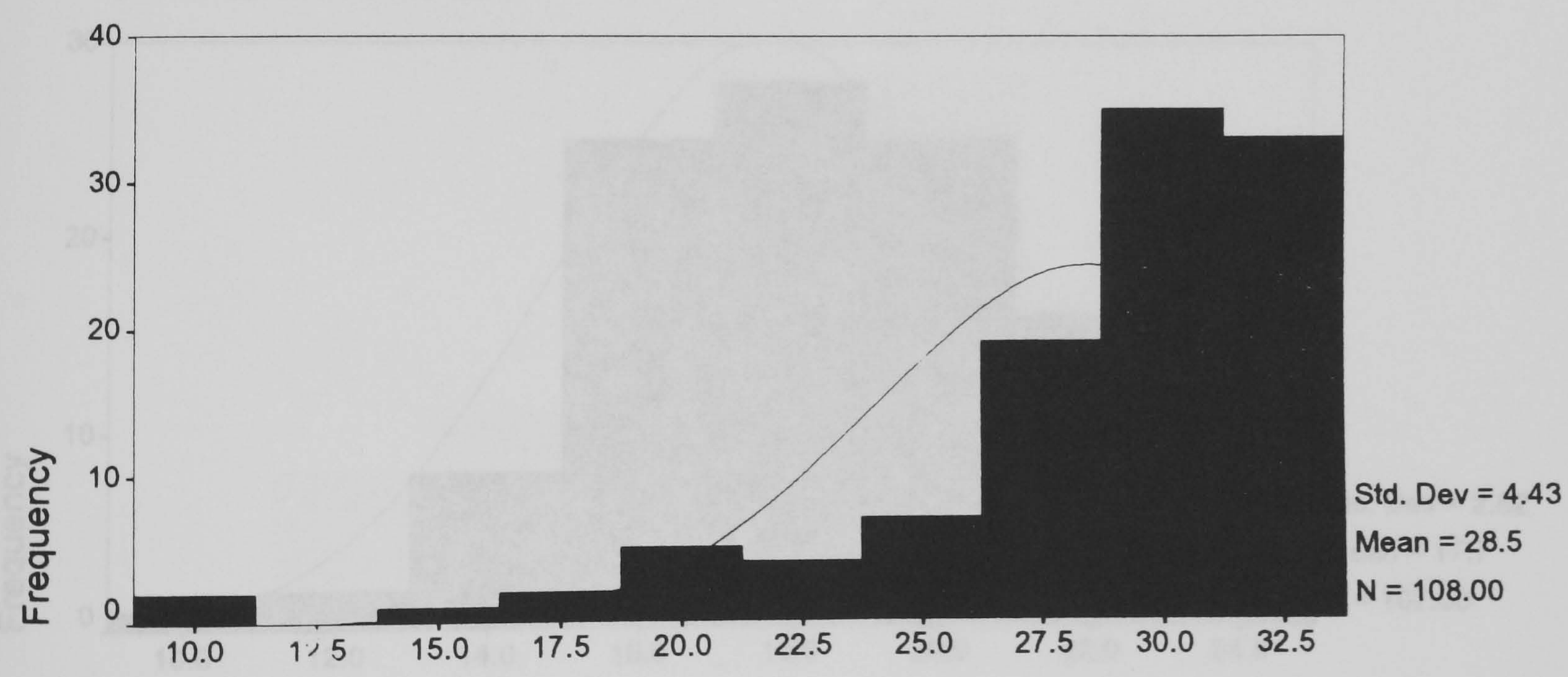
Normal distribution added



team identification

Distribution of professional identification scores

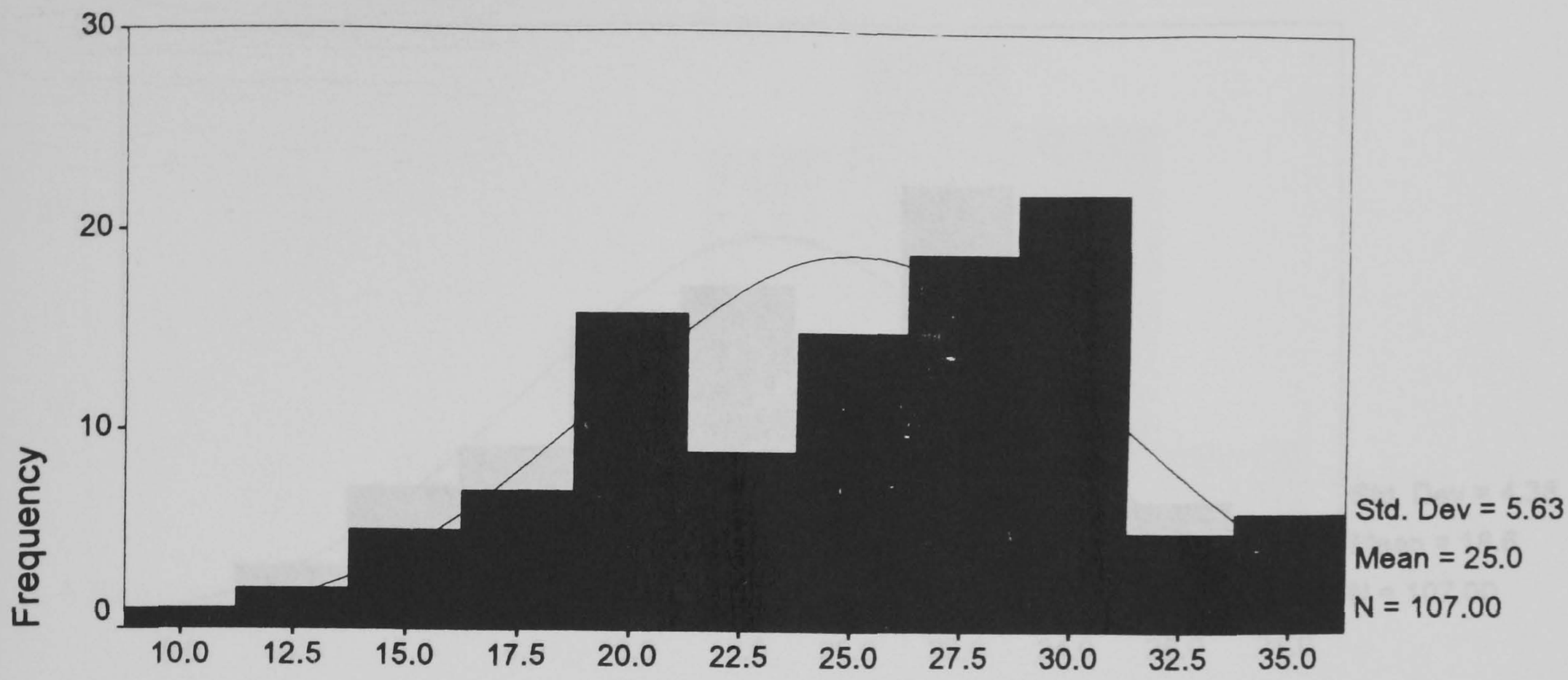
normal curve added



proff identification

Distribution of satisfaction with achievement value and growth scor

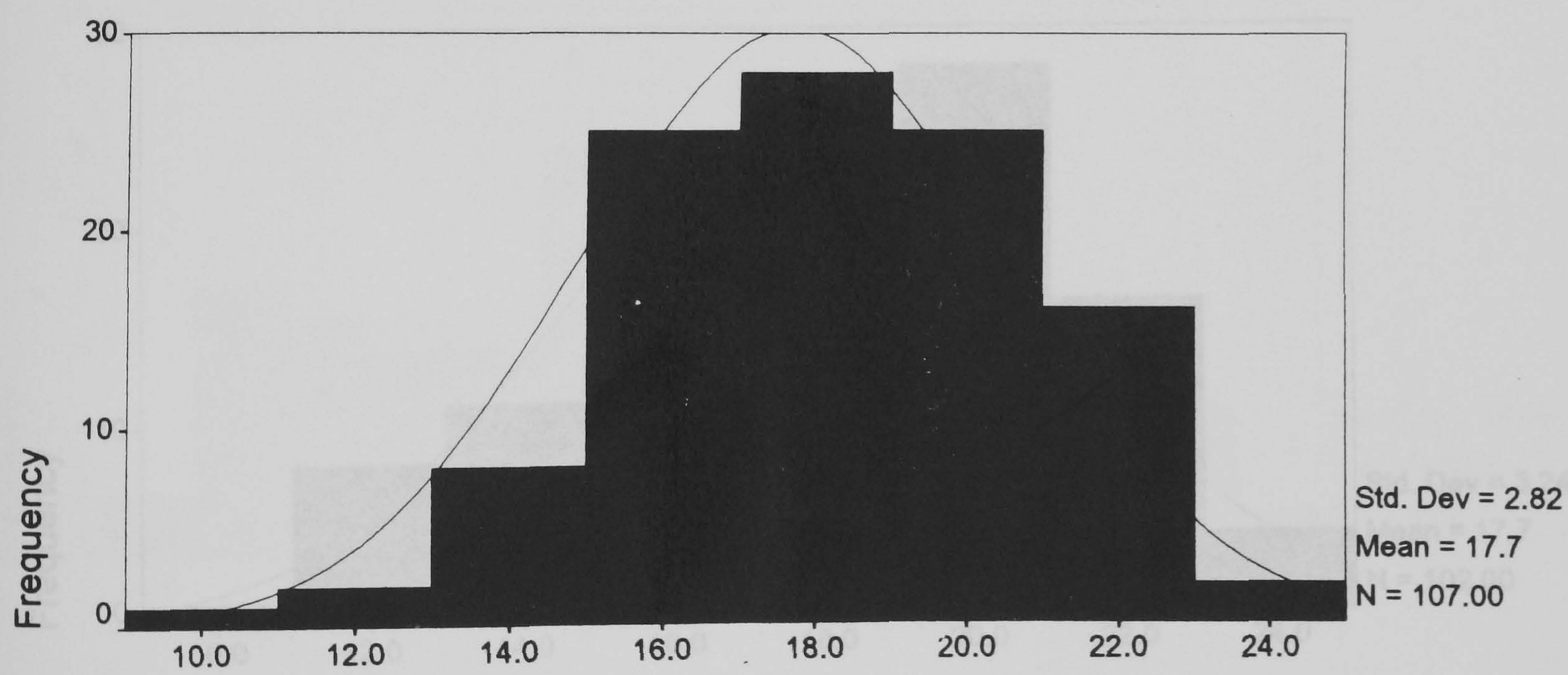
Normal curve added



Satisfaction achievement/value/growth

Distribution of satisfaction with job itself scores

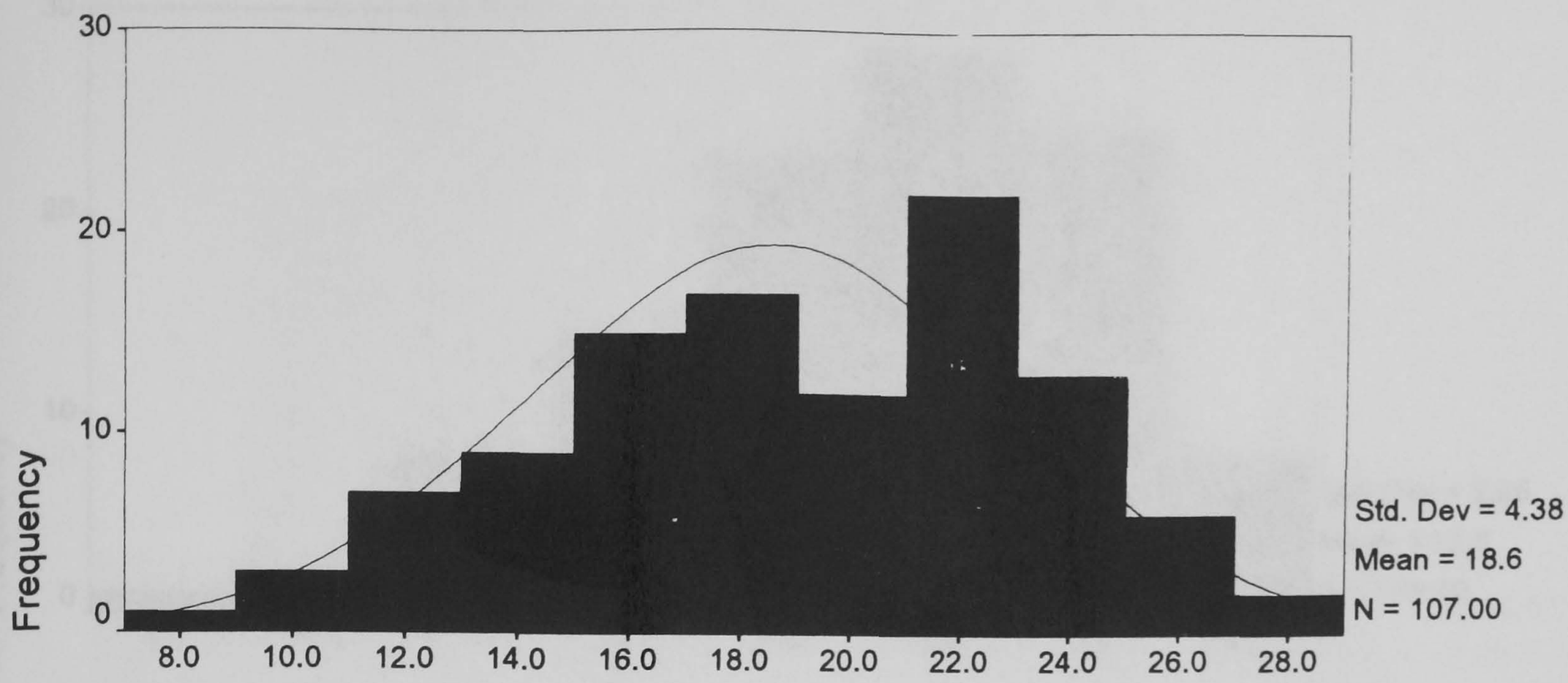
Normal curve added



satis job itself

Distibution of satisfaction with organisational design scores

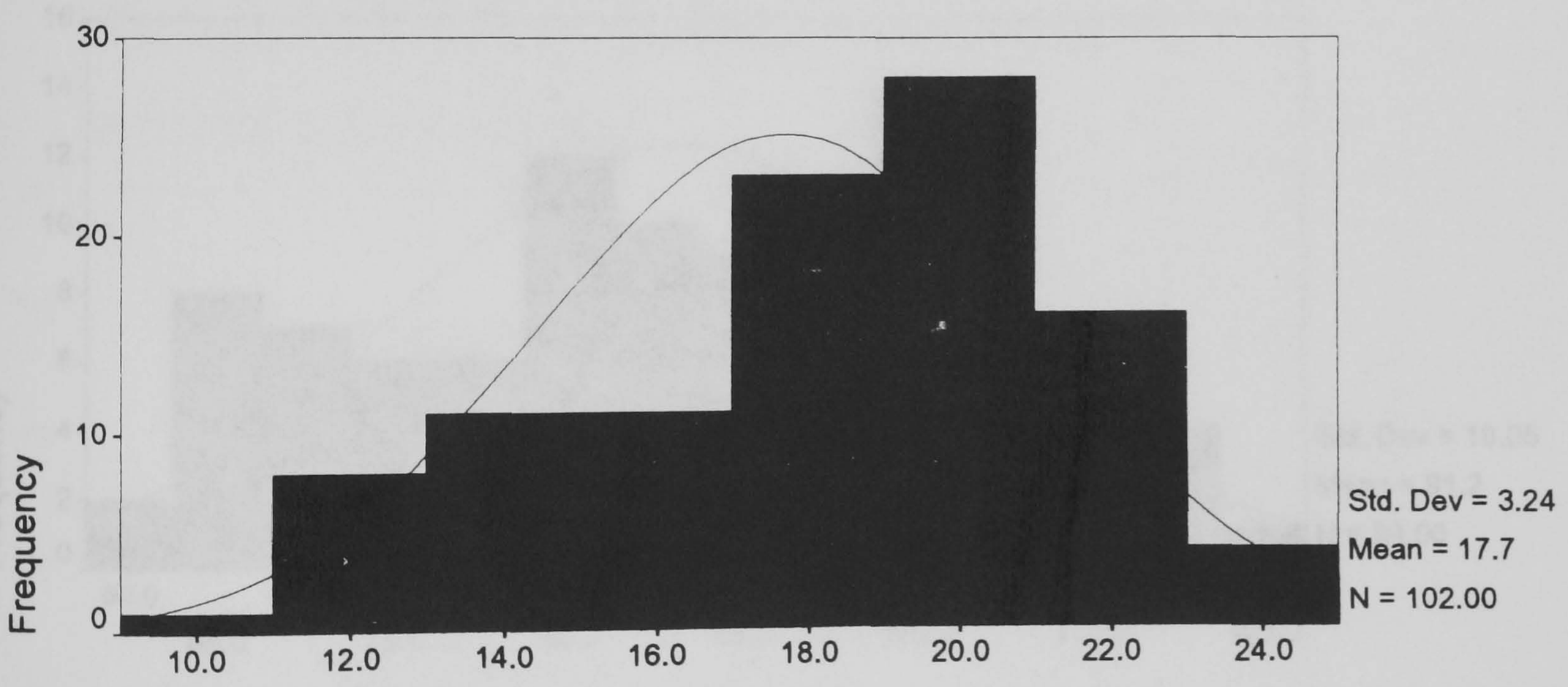
Normal curve added



Satis Organisation/design/structure

Distribution of satisfaction with organisational process scores

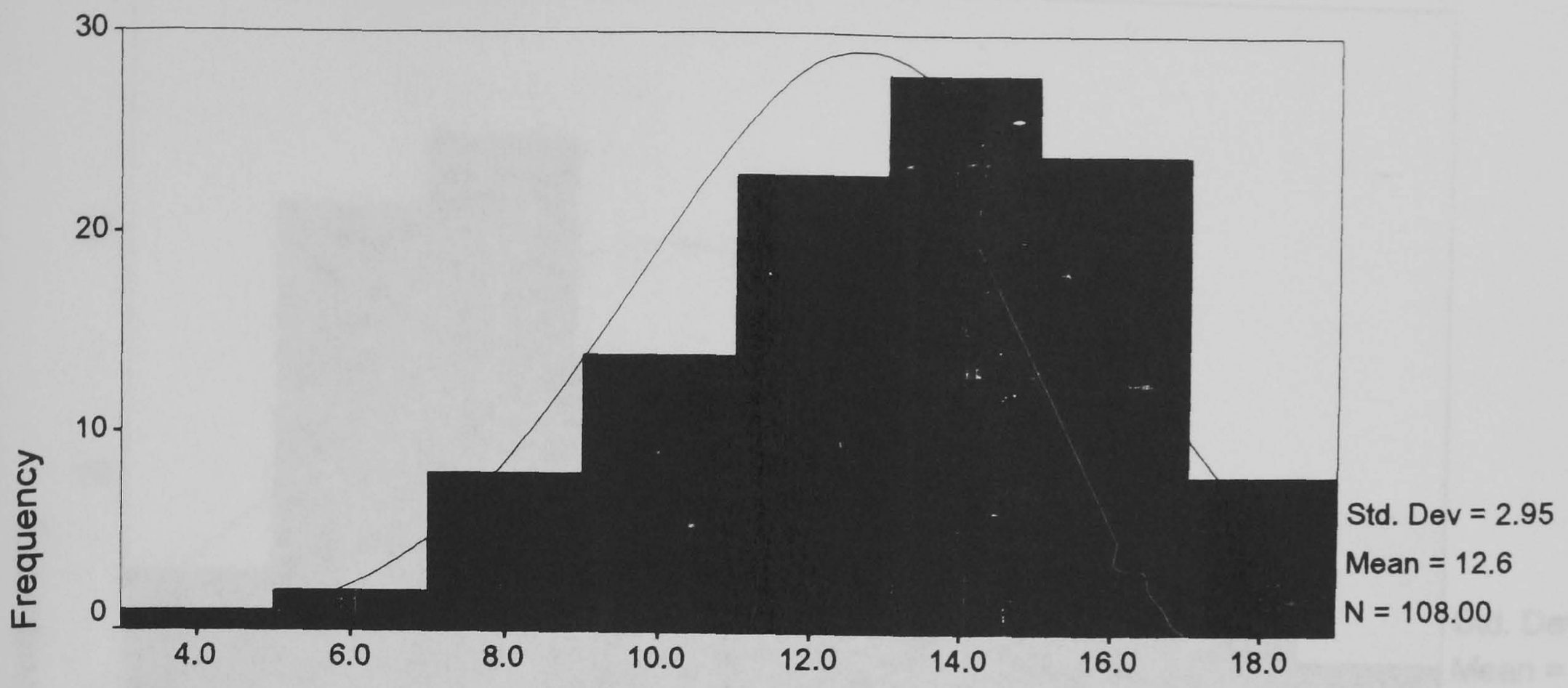
Normal curve added



satis organisational processes

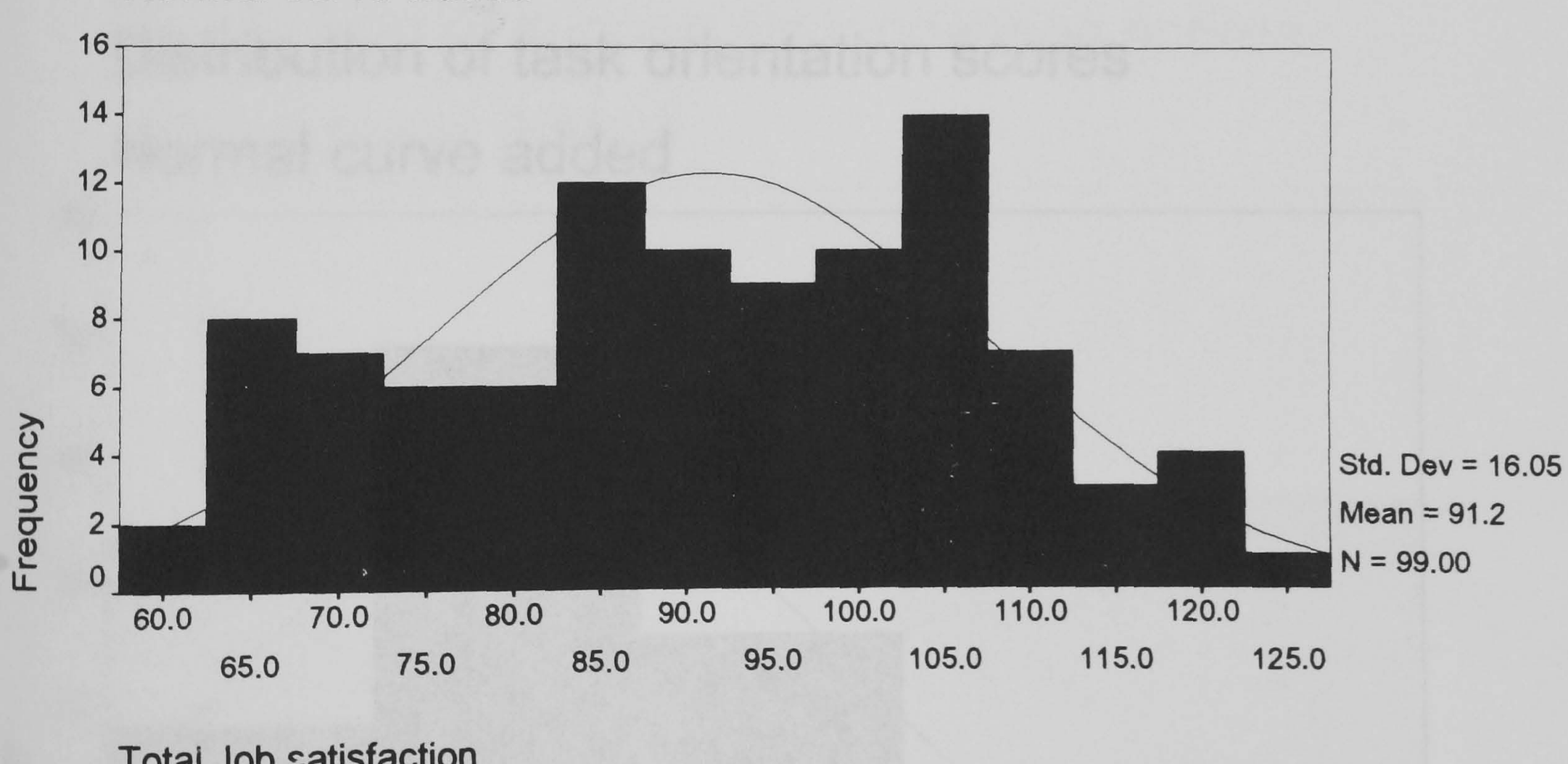
Distribution of satisfaction with personal relationships

Normal curve added



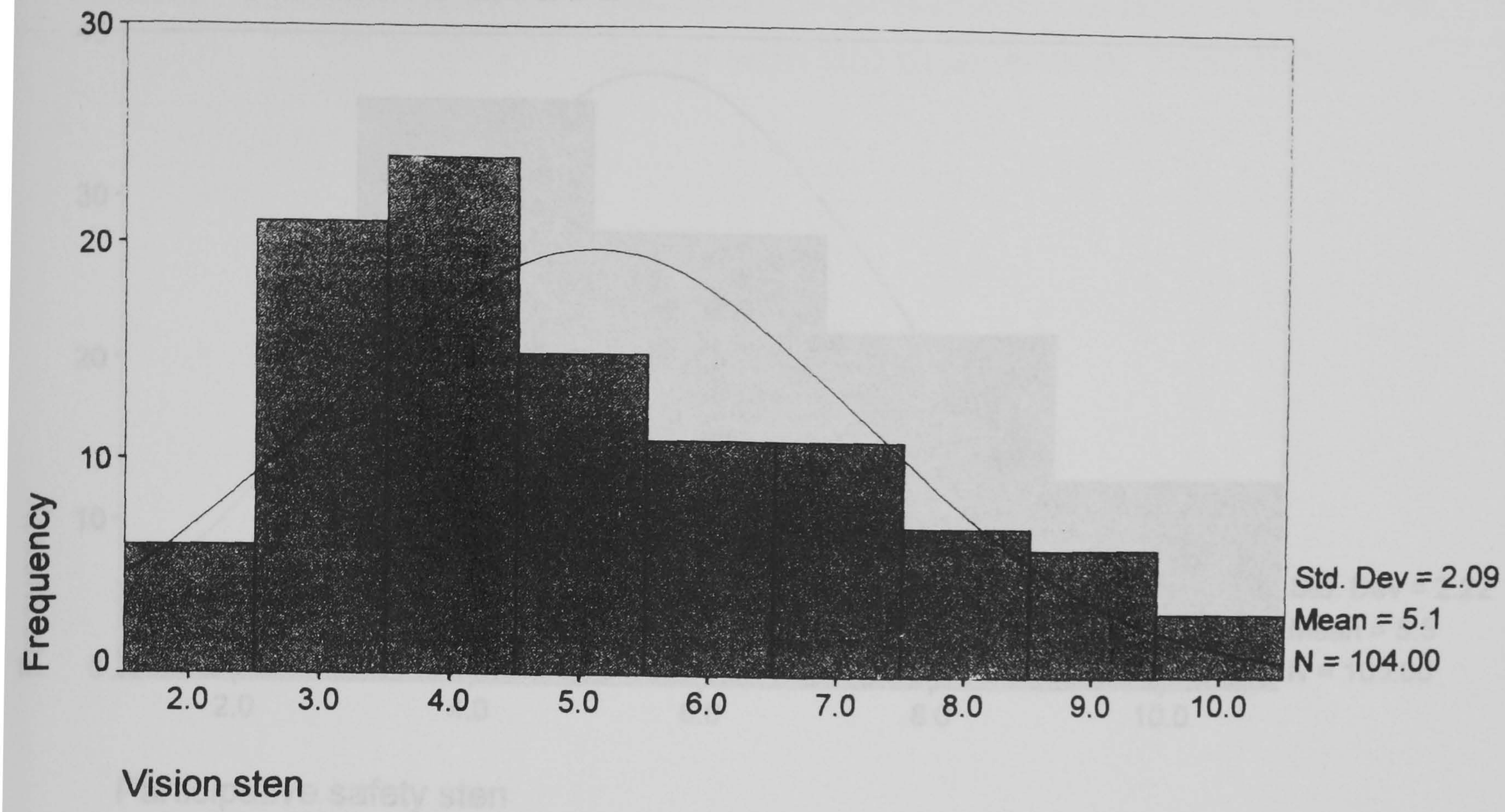
Distribution of total satisfaction scores

Normal curve added



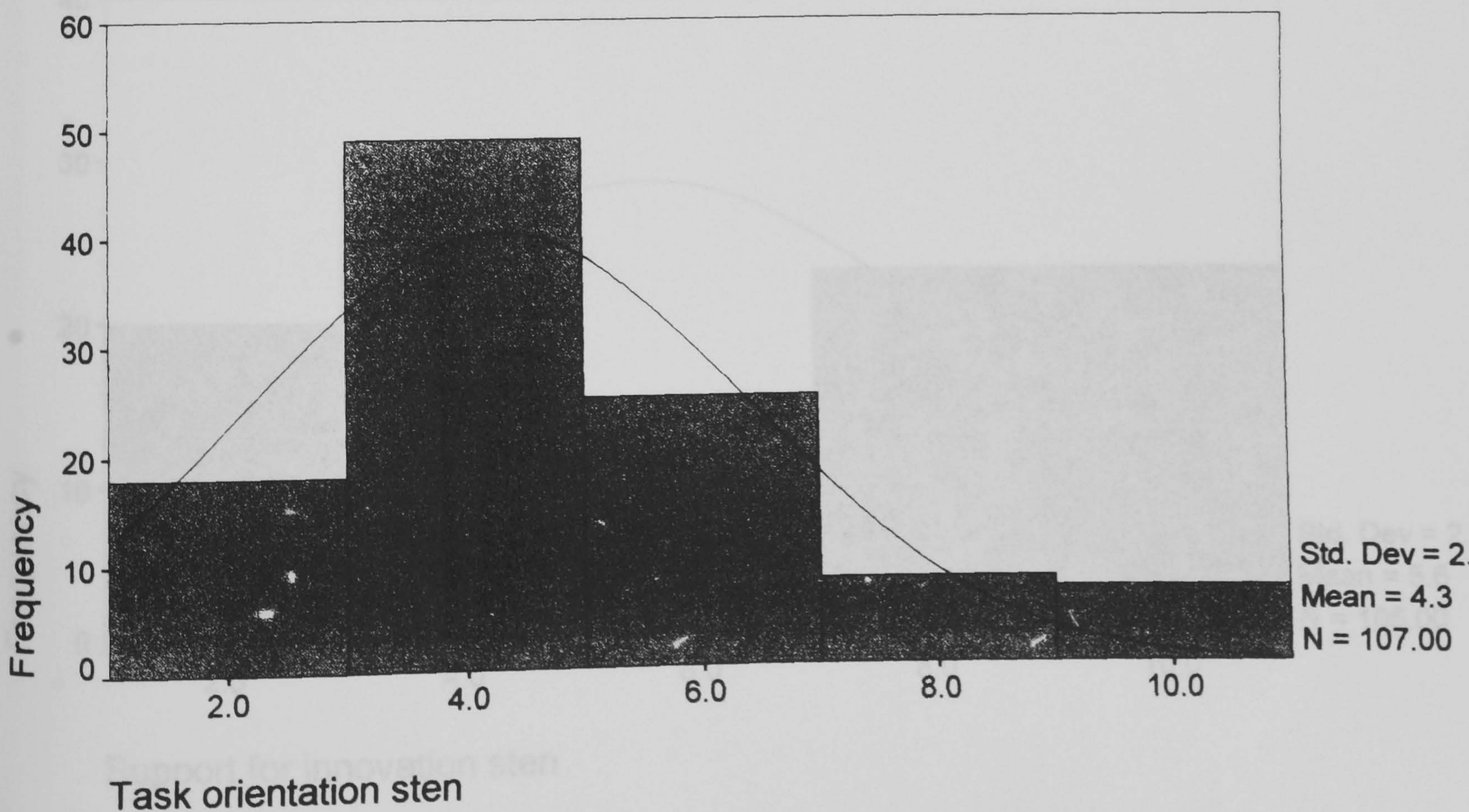
Distribution of vision scores on the TCI

Normal curve added



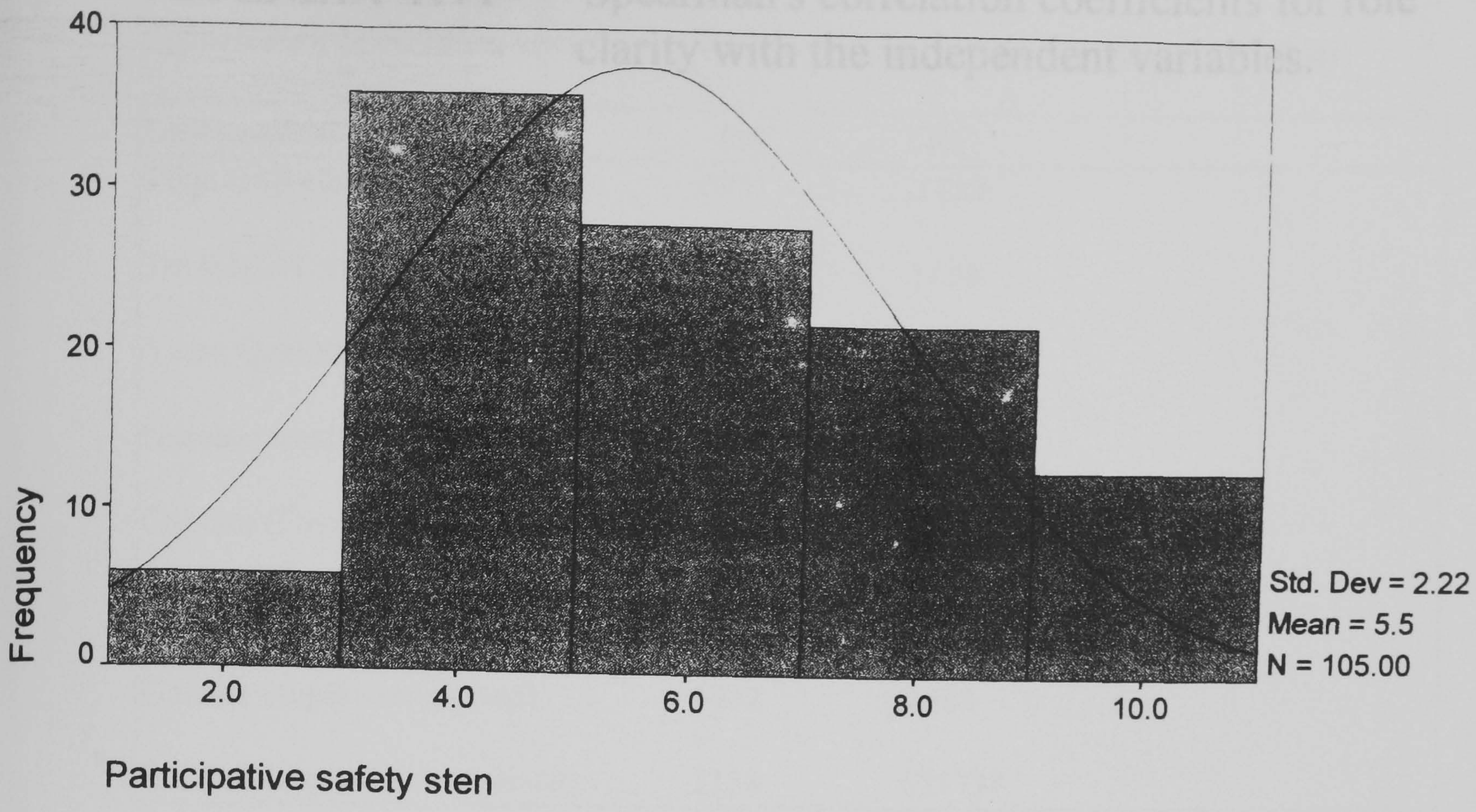
Distribution of task orientation scores

Normal curve added



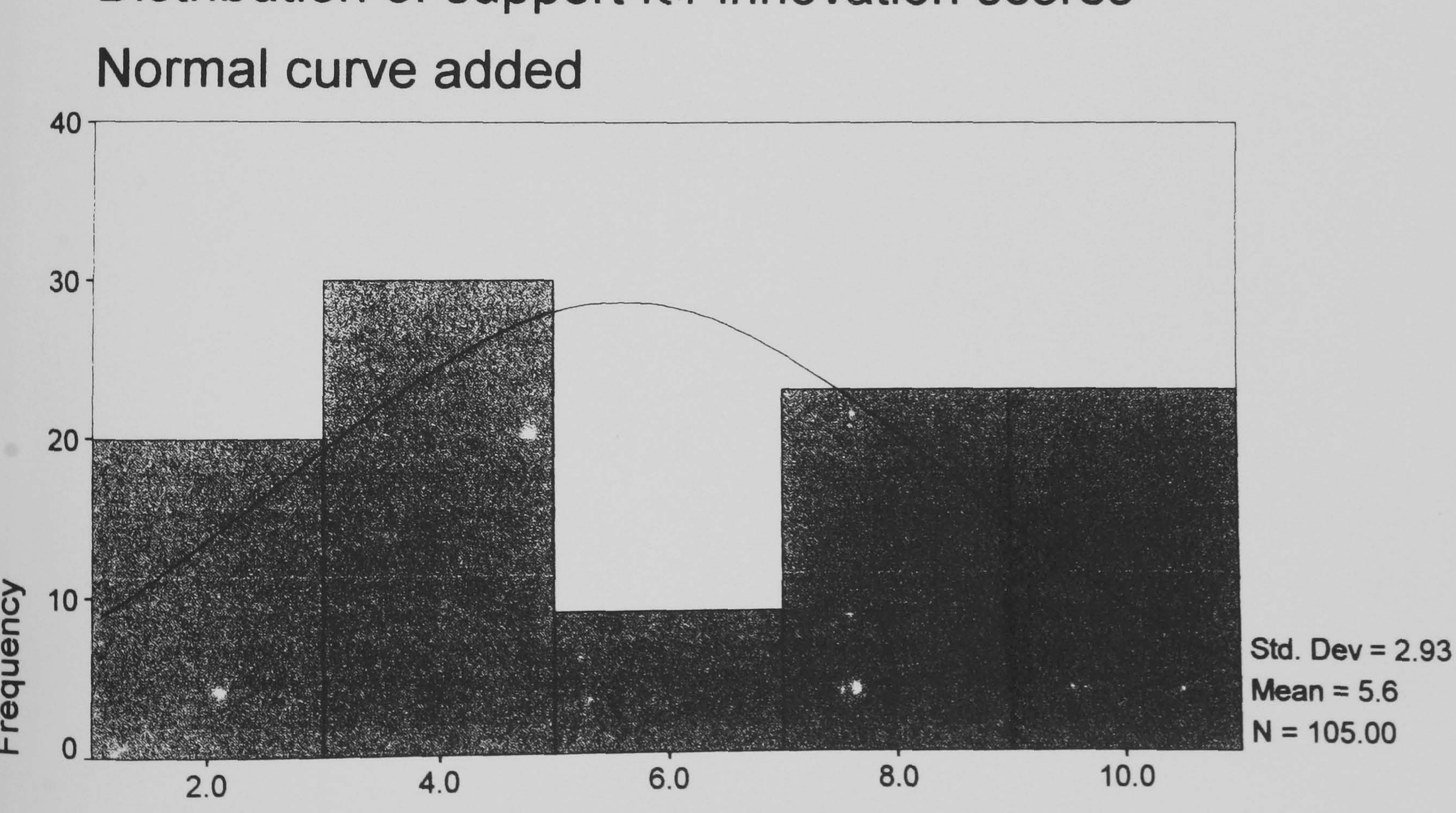
Distribution of participative safety scores

Normal curve added



Distribution of support for innovation scores

Normal curve added



APPENDIX XVI Spearman's correlation coefficients for role clarity with the independent variables.

Spearman's correlation coefficients for role clarity with independent variables.

Independent variable	PRC	TRC
Time with current team	.0951	.1130
Total MDT experience	.1459	.1488
Years Qualified as psychologist	.0463	.0637
Number sessions in team	-.1130	.0621
Contact (Dept Meetings)	.0653	.0899
Contact (Informal)	.1387	-.0088
Contact (supervision given)	.1752	.1583
Contact (supervision received)	.2158	-.2173*

*p<.05.
Key: PRC=personal role clarity; TRC=team role clarity

APPENDIX XVII The division of participant responses on the identification scales into "high" and "low" groups.

The division of team and professional identification scores into two groups.

The team identification scores were used to divide the sample into two groups: those with higher team identification and those with lower team identification. This was initially attempted using a median split of the scores. However as the median point score was 28 and a number of participants scored this value, a cleaner division was made between values 27 and 28, resulting in two groups of similar, but not equal, size. The high team identification group comprised of scores of 28 and above (n=57), while the low team identification group comprised of scores of 27 and below (n=50).

A similar procedure was conducted for professional identification resulting in two groups. The high professional identification group comprised of scores of 30 and above (n=58), while the low professional identification group comprised scores of 29 and below (n=50).